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ORIGINAL LECTURES.

CLINICAL LECTURE

ON A CASE OF FETID BRONCHITIS SIMULATING ABSCESS OF THE LUNG CURED BY THE OIL OF SANDAL-WOOD; AND ON A CASE OF TUMOR OF BRAIN WITH CROSSED PARALYSIS.

*Delivered at the Pennsylvania Hospital, January 22, 1887,
BY PROF. J. M. DA COSTA, M.D.*

GENTLEMEN,—This patient is about leaving the hospital to return to his work, and I will now lay before you the results of his treatment. He is about 32 years of age, and has been much exposed to fumes of nitric acid in some chemical works. He had articular rheumatism five years ago, and chills and fever twice within the last two years. He drinks whiskey steadily, but denies excess. He was admitted into the hospital December 16, with cough and profuse expectoration, sometimes bloody and offensive. He had emaciated greatly, complained of poor appetite, diarrhoea, and had vomited several times. He had frontal headache, and sweated freely at night. Altogether it was a very unpromising case.

Upon examination there was found, about the middle of the left lung posteriorly, some dulness on percussion, and, upon placing the stethoscope to the chest, moist râles and faint pectoriloquy could at times be obtained.

All this, however, was but a repetition of a previous note, for the man had been in the hospital last September in a very similar condition, and so great at that time was the amount of the expectoration, containing masses of purulent matter, that the idea of abscess of the lung was seriously entertained. He was somewhat benefited by treatment, and went out, only to return with the same symptoms; and, indeed, there is no evidence that they had ceased from the time that he was in the hospital. When he returned were found again the cough, fetid expectoration, nummular sputa, emaciation, and sweating, and other features which had given rise to the supposition of abscess of the lung.

When readmitted, he had a slight rise in temperature (100°); pain in his left side; frequent expectoration of offensive purulent matter, amounting to a pint and a half in twenty-four hours, occasionally blood-streaked. The sputum was examined microscopically, but no bacilli and no elastic tissue could be found.

Now, this man, with all the signs of constitutional disturbance, emaciation, sweating, and the like, with all the signs of disease of the left lung, was submitted to systematic treatment and carefully-regulated diet. He was given carbohc acid, and subsequently terebene by inhalation, and other agents; but none of those tried and retried gave any enduring results. I then thought of what I had used before in cases of profuse expectoration, and especially in bronchial catarrh with offensive discharge, as in fetid bronchitis, and I placed him upon the oil of sandal-wood, at first five minims three times daily, and afterwards five times daily. The results were most striking. After about a month's treatment the expectoration has almost ceased; he now expectorates no more than a drachm in the twenty-four hours. The dulness at the lower part of the lung is no longer to be perceived, his breathing is better, the râles have disappeared. There are no physical signs other than a little harshness of breathing at the point indicated.

I will not discuss the diagnosis of this case. I do not think that there was really an abscess, but that there was bronchitis with dilatation and accumulation simulating an abscess. I do not propose to go into this more particularly, but merely show him to you and direct your attention to the oil of sandal-wood as an agent acting decidedly upon the mucous membrane of the bronchial tubes. Its effects upon other mucous membranes, as in the genito-urinary tract,—as in cases of purulent urine from disease of the kidneys,—first led me to use it for the condition of bronchorrhoea. It has afforded great relief to such cases in my hands. I may say that this man was cured by the oil of sandal-wood; and I think it worthy of your consideration in connection with other resources for the treatment of chronic bronchitis, with or without fetid expectoration, to which I have already called your attention.

CROSSED HEMIPLEGIA DUE TO BRAIN-TUMOR.

The next case to which I will call your attention is a more protracted one, though less rare than the one you have just seen. This is a boy, 15 years of age; birthplace, Brazil. His mother, brother, and sister, he states, are healthy and strong. His father was killed. We found no evidence of inherited syphilis, and he informs us positively that there is no acquired venereal taint. He was always healthy until about a year ago. He went to school, but sometimes worked at mule-driving. This is all I can tell you with regard to his antecedents.

The present illness began, as he stated, about a year ago, when he suffered with frontal headaches, which became worse as time went on. He kept at work until last summer, when he fell and injured his head and leg. After this his headaches became worse, and vertigo appeared. His sight also was affected, so that he had to stop work. About two months ago he lost power in his right arm and leg,—not suddenly, but gradually. He also noticed that he could not feel objects touching the left side of his face, and the corresponding side of the tongue lost its power of taste. About the same time he became deaf in the left ear. For two weeks prior to admission he had a ringing in his right ear. For seven weeks he had been under treatment at an eye-hospital, but his sight grew steadily worse. He also had some difficulty in swallowing. His lungs, upon admission, were found to be normal. The splenic dulness was not increased. The urine was alkaline shortly after it was passed; specific gravity 1026; there was no albumen present. The frontal headache is still very severe at times, and strabismus, due to paralysis of the external rectus of the left eye, is observed. The pupils are dilated. He can see more distinctly with the right than with the left eye. There is no ptosis, but the left eye cannot be tightly closed, owing to orbicularis paralysis. The face is drawn slightly to the right, there is still partial anæsthesia of the left side of the face, and he cannot speak very distinctly. Hearing is impaired in both ears, but most decidedly in the left ear. Sensation and motion are still impaired in the right arm and leg, where the tendon reflexes are exaggerated. In the left arm and leg sensation and motion are preserved.

He has less headache this morning than usual, but it is still frontal in character. There is yet a decided difference between the two arms, and his grasp with the right hand is weak. He can kick better with his left than with his right leg, and in walking he barely lifts the right leg from the ground. He can walk with his eyes shut, though hesitatingly: he walks in a straight line. The patellar tendon reflexes are distinct on both sides. He seems intelligent, and takes interest in what is going on around him. His temperature is, and has been, normal: on one occasion only has it attained 99°.

I repeat the observation made on admission,—that there is no heart-lesion. The pulse ranges from 80 to 90. There has been no vomiting. Tongue slightly coated; bowels tend to constipation. He has not been delirious at night. His mind is always as clear as at present, but he has not a very good recollection of dates. It is a steady headache that he complains of; he has had no vertigo since his admission. He is still unable to close the left eye.

Now, gentlemen, I have told you all about this case except the report of ophthalmoscopic examination. The pupils respond to light. There is complete paralysis of the external rectus of the left eye, and paralysis of the orbicularis. The vision of both right and left eyes is impaired. Optic disks are swollen; veins are enlarged. There are striated hemorrhages just above the disk in the left eye. We have, therefore, choked disks, with hemorrhages. [Patient taken out.]

What is the explanation of this group of symptoms? There are only two suppositions that are plausible. This patient has chronic meningitis with thickening, most marked at the base of the brain, principally upon the left side; or he has a brain-tumor. I cannot see how else to explain the phenomena of defective sensation upon left side of face and tongue, deafness in the left ear, with paralysis of muscles of the left eye, together with motor paralysis of the right side of the body. On no other supposition than the presence of an exudation or a tumor could we understand the evident existence of pressure. Let us discuss this question. Is it a tumor, or is it meningitis? In the first place, we have a very obscure history. The boy had violent headaches before he fell and struck the back of his head; on

the other hand, he had no specific history nor anything to give rise to a tumor. Everything is in favor of meningitis caused by a fall, except the history of prolonged attacks of headache before the fall took place. The symptoms presented have more of the character of those caused by meningitis than of those caused by a slowly-growing tumor. But having approached the subject with unbiassed mind, and after going over the facts, I conclude that the boy has a brain-tumor rather than meningitis. Notwithstanding the history and the points which favor meningitis, the evidence is against the view that there is sufficient meningitis to produce these symptoms. In the first place, you have noted the entire absence of fever. My experience with chronic meningitis is that it gives rise to exacerbations of fever; during the day the temperature may be normal, but at times there will occur nocturnal fever associated with delirium. Another point is that in meningitis the superficial portions of the brain, too, become affected, and there is either irritability of temper or impairment of memory; or, in other words, that other cerebral symptoms are apt to be present besides those of headache and paralysis. The boy's memory is good except for dates, and he has a good temper. These are strong points against meningitis. I may add another one, though of less value than those I have mentioned. This boy has had no convulsions. Yet I do not lay much stress upon this, because in brain-tumor you may also have convulsions. You will ask, Does the eye-examination give any light upon the diagnosis? No. The conditions found might be all accounted for by the pressure exerted in either case,—by an exudation as well as by a tumor; though the hemorrhages and signs of intense pressure are more in favor of a tumor as the cause than of meningitis.

Now we shall turn our attention to some points which need discussion in connection with the diagnosis of tumor. Let us ask, Where is it situated? What is its character? With reference to the last question, the nature of the growth is rather obscure. But from its slow course I conclude that it is not cancer, but, probably, one of the forms of non-malignant growths due to increase of areolar tissue. It is not aneurism, because there is no whirr or thrill perceived when the stethoscope is applied over the temporal region.

My belief, then, is that it is not cancer and not aneurism, but a connective-tissue, non-malignant growth.

Where is the site of this tumor? It is not always easy to say where the tumor is situated. Sometimes due consideration of the special senses affected, together with our knowledge of the physiology of the cranial nerves, will enable us to decide very positively upon the locality of the lesion; in other cases it may be impossible. In this case I think that I can locate this tumor satisfactorily. Here is a crossed paralysis,—left side of face and right side of body,—and loss of sensation on the left side of face and tongue. This can be produced only by a lesion very low down, but yet above the point of decussation of the motor tracts. The growth must be on the left side of the brain. It must be near the origin of the gustatory nerve, and must also be in a position to press upon the portio mollis of the seventh nerve going to the left ear; the portio dura is also affected, as is seen in the paralysis of the facial muscles. This is clear. For the reasons assigned, the growth must be on the left side of the brain, and at its base, at a point where it would be in contact with the nerves passing from the medulla and pons.

As the hour has expired, I will merely state, in regard to treatment, that the boy has been taking large doses of iodide of potassium, and is doing well on it. I do not know anything better. With this, small doses of bichloride of mercury have been administered (ten grains of iodide and a twenty-fourth of sublimate three times a day). He has now been taking this for ten days. He declares that he feels better, he has less headache, and he walks better. There is now very little impairment in his gait. I have spoken about the advantages of iodide of potassium in the treatment of brain-tumor before, and need not now refer to them again. Shall we continue this treatment, or shall we increase the iodide to twenty grains three times a day? We will gradually increase the remedy to larger doses as long as he improves under it or until the symptoms disappear. This is not done because I have any idea that the boy has syphilis, but because it does good irrespective of syphilis. In addition, he might derive some relief from a blister applied behind the ear. A laxative might be given two or

three times a week, and if the headache prevents sleep he shall have some chloral hydrate at night.

ORIGINAL COMMUNICATIONS.

THE IRRITABLE HEART AND THE DEPRESSED HEART.

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(Continued from page 407.)

IN the description of the pathological consequences of this condition which is to follow, I trust the justification of this name will be found.

It is hardly necessary to state that many of the patients affected in this manner have never suffered from irritable heart. I have thought it not uninteresting, however, to contrast the symptoms of the two conditions, in order to bring out more clearly their differences.

Physical examination of persons after middle life, especially if they have a tendency to corpulence or are in easy circumstances,—i.e., are not required to perform hard physical labor,—will often show a weak, or quite imperceptible, apex-beat. Life-insurance examiners frequently make this observation, but without attributing any serious meaning to it. If the area of dulness and the heart-sounds are normal, and other evidences of good arterial circulation are present, the asthenic apex-beat and the frequency of pulse are ascribed to nervousness, excessive use of tobacco, or the emotional excitement produced by the examination. The insurance official is probably justified in ignoring this symptom in many cases, for it is, in the early stages, not significant of pathological alterations in the heart or of diminished cardiac power. It has been likewise shown that the strong, sharp apex-beat of irritable heart is not an evidence of increased cardiac power, but a symptom of abnormal innervation. A strong apex-beat may likewise be present in conditions of great structural alteration of the heart, as in the striking case of Mrs. Tate related by Balfour.* This patient was over eighty years of age at the time of her death, and had long suffered from

angina pectoris, for the relief of which hypodermic injections of morphine and inhalations of chloroform had been used. "After death, the aorta was found dilated, the orifice of the middle coronary artery—there were three in her heart—almost entirely blocked up by atheromatous deposit, and her heart not only thinned and somewhat dilated, but of a pale yellowish tint, soft, and thoroughly fatty; no muscular fibre could be more completely degenerated; yet chloroform produced in her no dangerous symptoms, and, far from shortening her days, seemed certainly to prolong them. I may also add that *her apex-beat was tolerably firm to the last.*"

This case proves that the force of the apex-beat has no relation to degenerative changes in the heart-tissue, and is not significant of such changes.

Several elements combine to produce the cardiac impulse: first, the impact of the apex of the left ventricle, which in contracting forms a hard, conical point, and, by a slight twisting motion during contraction, is thrown to the front and made to strike against the chest-wall; secondly, the recoil of the heart at the moment of the emptying of the ventricles.

The changes of position of the heart during systole and diastole may be compared to a "see-saw" motion. As the apex rises towards the chest-wall during contraction, the twisting movement above referred to causes the lower end of the ventricle to come to the front and impinge with some force against the ribs or intercostal space. If now, without any loss of force in the contraction, the twisting and turning forward of the ventricular apex is changed or diminished in extent, the impact against the chest-wall is diminished or perhaps entirely abolished. It will hence be readily understood how, in young persons with irritable heart but no restriction of the twisting movement or in the normal systole, the abrupt contraction of the ventricle forces the hard point or apex sharply against the anterior wall of the thorax, and produces the strong impulse and concussion which are such noticeable symptoms of an irritable heart. Even in fatty or atrophied heart the normal impulse may be maintained so long as the twisting upon the longitudinal axis of the ventricle takes place during contraction.

In older, fleshy patients, on the other

* Diseases of the Heart and Aorta, p. 285. Philadelphia, 1876.

hand, in whom the symptoms of nervous depression are more prominent, the abrupt, jerky contraction of the ventricles has given place to a more regular systole. In consequence of the overfilling of the venous system, to be presently described, the right ventricle is more encumbered by the mass of blood, and the twisting movement by which the left ventricle is brought to the front during systole is incompletely executed, and the apex does not strike the chest-wall with the normal impact. The slight concussion of the chest which may be felt is merely an expression of the cardiac movement as a whole. Although this symptom is also recognized as one of excentric hypertrophy of the right ventricle, there is no dilatation present in the cases above described. The right ventricle is merely filled beyond its average capacity, while the left is only normally, or less than normally, filled. Inasmuch as there are no actual changes of size and form in the heart as yet, the area of cardiac dulness and the point at which the apex-beat may be felt on deep inspiration and stooping posture remain normal. This normal place of the cardiac apex-impact is in the fourth or fifth intercostal space (oftener in the latter), about two inches to the left of the left lateral margin of the sternum. The heart-sounds are normal, with the exception of a sharp accentuation of the second pulmonary sound, which is due to the increased labor of the right ventricle.

We owe to Oertel the explanation of the turgidity of the venous system found in these patients. I am of the opinion, however, that this acute observer attributes too much importance to fatty heart, and assumes its existence in too many cases, while entirely overlooking the absence or weakness of the apex-beat in relation to the condition under consideration.

While acknowledging and valuing the labors of such masters as Da Costa and Oertel in this field, the careful and observant family-physician, with his opportunities of following the careers of his patients through a lifetime, may note facts or arrive at conclusions which, from their brief period of observation, are not available to the hospital physician or the consultant.

Professional persons, or such as are in easy circumstances, consume, as a rule, a quantity of liquid and solid food which would more than suffice for the nutrition

of a stevedore or hod-carrier. The venous system of the abdomen is admirably adapted to act as a temporary receiver for the excess added to the blood by absorption from the intestinal canal. The abdominal veins are capable of taking up a quantity of blood equivalent to the average mass of the entire blood-supply of the body.

These veins, including both those of the portal and general abdominal circulation, together with the chyle and lymph-vessels, take up all absorbable, especially the liquid, portions of the food from the intestinal canal, and convey them into the right auricle, and thence into the right ventricle. If the heart is healthy, it soon disposes of the larger amount of blood passing through it by more rapid contraction. Inasmuch as both ventricles contract synchronously, it happens that the left ventricle is less completely filled at each contraction than the right. The arteries, in consequence, are distended, the pressure in them decreases, and a diminution in force and increase in frequency of the pulse result,—the former owing to the lessened blood-pressure, and the latter owing to the more frequent cardiac contraction.

But our fleshy patients may still maintain their health, because the excess of liquid taken in increases the activity of the skin and kidneys. If sufficient bodily exercise is taken, the rapid and energetic muscular contractions support the turgid veins and lymphatics, and aid in restoring the normal circulation. To accomplish this, regular and moderate bodily exercise is beneficial, while spasmodic or violent exertions, with long periods of rest, are vicious. Moreover, if to the overfilling of the veins and right side of the heart above mentioned be added the customary prescribing of large quantities of mineral waters and liquid diet, for the purpose of increasing the intestinal and renal secretions, the morbid condition will become more sharply defined.

The patient perhaps still takes active exercise occasionally, he perspires freely, his kidneys act fairly well; he is still healthy so far as a physical examination can determine, with the possible exception of slight catarrhs, neurasthenic symptoms, urine of high specific gravity but not containing albumen or sugar: in short, he presents the collection of symptoms above described as belonging to a case of depressed heart; although the insurance offi-

cial, basing his opinion upon the physical examination alone, and not looking into the future, would still be justified in accepting the individual as a good risk.

Should a favorable change now take place in the condition and mode of life of the patient; if he engage in more active exercise, stimulate the functions of the skin by means of baths and frictions, reduce the amount of food and drink consumed, and if the food be more thoroughly masticated and digested, then the abdominal veins will be less distended, the general vascular system better supported in moving the blood-current, the arteries better filled, and the entire circulation equalized. As in the other case all the circumstances combined to characterize more sharply the clinical picture of the depressed heart, so in this all these abnormal conditions gradually pass away, and after months, or possibly years (for improvement goes on slowly), the health may be perfectly re-established, thus justifying the favorable opinion of the insurance examiner to which we referred.

But should the consumption of solid food and liquids, even though the latter consist only of water or other indifferent liquids, continue, or if the amount of drink be increased in consequence of habit, thirst, or even medical advice, then the renal excretions decrease on account of venous congestion, the functions of the skin diminish through lack of exercise, baths, and frictions, the return of the blood from the lower portions of the body becomes impeded owing to deficient muscular contraction, and the heart, already predisposed to relaxation, is subjected to additional strain. The engorgement of the pulmonary circulation embarrasses the respiration, and thus diminishes the metabolic activity in the lungs and tissues. As a consequence, the products of suboxidation—uric and oxalic acid, urates and oxalates—are produced in excess, instead of urea.

The proposition of Weber—that the pulsation of the heart is not transmitted to the veins—loses its force here. The arteries, stimulated to excessive contraction in order to overcome the high blood-pressure in the capillaries and veins, begin to manifest the results in endarteritis and analogous pathological processes. The continued engorgement of the right ventricle leads to dilatation and compensatory hypertrophy of the right heart, which is fol-

lowed by similar changes in the left heart. The hypertrophy of the left ventricle easily becomes greater on account of its greater muscularity, and because the already diseased arterial walls furnish an additional obstruction to overcome. The prolonged engorgement of the kidneys, acting upon the nervous supply of these organs, gives rise to increased secretion, and arterio-capillary fibrosis is established. The constant turgescence of the hepatic veins, together with the irritation of the parenchyma of the liver by spirituous drinks, may lead to excessive diapedesis of the accumulated leucocytes in the dilated veins and new formation of connective tissue, ending in cirrhosis; or the endarteritis produces miliary aneurisms or apoplectiform extravasations of various sizes, or scleroses in brain and spinal cord.

When these conditions are fairly established, the symptoms of depressed heart give way to the manifestations of organic disease, such as chronic gout, gravel, cirrhosis, Bright's disease, sclerosis, etc. When the morbid condition has progressed to this stage, restriction of food and drink and medicinal therapeutics may arrest it, but can no longer cure. The insurance examiner who passed the individual made a grave mistake in overlooking the symptoms of depressed heart and ignoring their possible consequences.

According to my experience, the favorable ending first described above is exceptional, unless the individual changes his mode of life. Now, inasmuch as the insurance examiner would be exceeding his privileges if he attempted to act as medical adviser to the applicant, the former should, in the interest of the company, be exceedingly cautious in accepting as good risks persons with weak or imperceptible apex-beat combined with the other phenomena of depressed heart. He should, at least, take into consideration the applicant's occupation and mode of life.

The current opinion that corpulence alone will cause weakened cardiac impulse is not confirmed by my experience and observation. If the cardiac innervation be normal, and the heart neither engorged nor underfilled, so that the twisting of the left ventricle takes place to the front during the systole, the apex-beat will be distinctly perceptible, even if a considerable thickness of adipose tissue interposes between the heart and the examining finger.

A few points in regard to the therapeutics of this condition may be here added. Each case must be thoroughly studied, and treated according to the special indications. Restriction of fluid and increase of solid food cannot be ordered indiscriminately, because the excessive consumption of liquids is not the sole cause in all cases. A very corpulent female patient whom I had under treatment for depressed heart illustrates this very well. The quantity of fluid ingested daily did not exceed two pints; the patient ate comparatively little, and was kept pretty actively employed during the day by her household duties. The only abnormality in her dietary that could be discovered was that the liquid consumed consisted of very strong coffee and that she ate much confectionery between meals. The medicinal treatment consisted of a placebo, but the sweetmeats were strictly forbidden and the strong coffee substituted by weak tea or *café au lait*. The morbid phenomena have after a few months' treatment entirely disappeared, and the apex-beat is again becoming distinctly perceptible. As a rule, corpulent persons are habitually thirsty and liable to overload the venous system by yielding to the demand for fluids. Hence the first therapeutic indication is to endeavor to equalize the ingested and the excreted liquid. If a true gastric catarrh exists in combination with the other symptoms, it will often be necessary to order a fluid or semi-fluid diet, but it will be of prime importance in these cases to stimulate the excretory organs. Baths, frictions, exercise in the open air, gymnastics, massage, or faradization will be indicated in addition to supervision of the dietary. The fluids ingested should be such as will act as stimulants to the secretory functions of the skin and kidneys, but it will be better, on the whole, to reduce the quantity of liquids taken than to consume them in excess and afterwards remove them from the body by evacuants (laxatives, diaphoretics, etc.). A proper reduction of the amount consumed will diminish the mass of venous blood, while active exercise in the open air, especially moderate mountain-climbing, will promote the arterialization of the blood. The food should be easily digestible, and should exclude such articles as are prone to form injurious compounds in the body,—for example, tomatoes, which are so rich in oxalates.

According to Flint, the average quantity of fluid consumed is from fifty to sixty ounces. This should be sufficient for an active working-man in summer. In winter, for one less actively employed, half of this should suffice for all demands of the economy. The physician must exercise common sense in regulating the quantity of fluids consumed in accordance with the patient's condition and mode of life. Hard and fast rules are not applicable here.

When the above indications are correctly appreciated and consistently carried out, the results obtained are often very surprising and gratifying. After a month or two of the treatment, the quantity of urine increases relatively to the amount of liquid drunk and the specific gravity approaches more nearly to the normal figure, the uric acid diminishes, the moist eczemas disappear without special treatment, the joints lose their stiffness, the muscular movements become more elastic, the sexual desires and powers return, and after from four to six months a decided improvement in the force of the apex-beat is noticeable.

The objection may be raised that many persons eat much and drink still more, and yet retain their health. But these persons are endowed by nature with a resistant organization which enables the circulatory and excretory organs to withstand the evil effects of temporary strain. Their mode of life is such as to preserve a proper relation between consumption of food and excretion of excess of fluid and the products of metabolic activity. *When, however, these individuals change their habits, and, instead of taking a reasonable amount of bodily exercise, sit and drink by the hour, no matter whether the drink be wine, beer, cider, or water (stronger liquors are, of course, out of consideration altogether), without a corresponding increase in the renal secretion, they are soon driven to consult a physician for the relief of the symptoms of depressed heart.*

Another point may be here referred to. There certainly are persons who, in spite of great moderation in eating and drinking, become very corpulent, although according to my experience they are rare exceptions. In these cases I have always found an apex-beat of normal force, or, at all events, strong enough to be distinctly felt. Where the latter was imperceptible, some

other disturbance of the circulation could easily be discovered on careful investigation.

It is not asserted that a distinctly perceptible apex-beat is to be considered as a certain indication of a healthy heart. Slight displacements of the heart due to previous changes in the thorax may cause the apex-beat to be felt in the normal situation, although the heart may show distinct disease. The case above quoted from Balfour is also in point.

I have endeavored to point out in this paper the importance of attributing a weak or imperceptible cardiac impulse, when joined to the other symptoms mentioned, to a depressed heart. It is extremely important to the patient that this condition shall be early recognized, and its causes sought out and removed before the beginning of organic changes. The causes will generally be found either in the consumption of too much food (fluid or solid), lack of exercise, lack of attention to the skin, too little fresh air, indigestion from deficient mastication, too rapid eating, improper or irritating diet, mental and physical overwork, abuse of the natural powers, excessive use of coffee, tea, or tobacco, or in a number of these combined. The removal of these causes is the first indication in treatment. The use of medicines is secondary.

In conclusion, it may be stated that exact sphygmographic and cardiographic observations, as well as correct time-measurements of single heart-contractions both in the irritable and in the depressed heart, are beyond the range of possibility to a family physician. Competent hands should take up this work, and by exact scientific observations check the clinical experiences which I have here set down.

REPORT ON THE PROGRESS OF OTOTOLOGY.

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(Continued from page 409.)

CARIES OF THE MASTOID.

W. KIRCHNER (*Würzburger physikalisch. med. Gesellschaft*, and *Archiv f. Ohrenheilk.*, Bd. xxiv. p. 61, 1886), in examining the ear of a young man who

was in a surgical clinic on account of gangrene of the muscles of the neck, found an extensive carious destruction of the mastoid portion which had been caused by the gangrene. A post-mortem examination revealed that the mastoid portion was nearly entirely destroyed, the sinus transversus exposed for a space of three centimetres, and also that a large destruction had occurred in the external auditory canal. The membrana tympani was nevertheless intact, and the tympanic cavity contained but little pus and its mucous membrane was but little thickened.

RUPTURE OF THE INTERNAL CAROTID ARTERY SUBSEQUENT TO NECROSIS OF THE TEMPORAL BONE.

Dr. T. Y. Sutphen, of Newark, New Jersey, gives an account of a fatal result from the above-named causes (*Archives of Otology*, vol. xv. No. 4, 1886). The patient was a man 25 years old. When a child he received a blow upon his right ear, which, resulting in a discharge, continued with varying intensity until the time of his coming under recent observation. An abscess beneath the ear had formed some years previous, and, forming again, he had sought relief. Examination revealed a swollen condition of the auditory canal, a tympanic cavity blocked with granulations, and the probe revealed the presence of denuded bone. The abscess beneath the ear was shown to communicate with the tympanic cavity. In the course of five months from this observation by Dr. Sutphen, the patient was again seen as an inmate of the hospital, when it was ascertained that facial paralysis on the right side had made its appearance about three weeks previous, and that within three days the left side of the body had become paralyzed. Severe pain in the right side of the head, dizziness, and nausea were complained of. The patient would not permit any operation for the removal of dead bone. Under tonics and hot fomentations to the ear the patient recovered the use of the paralyzed side, and in three weeks left the hospital. The facial paralysis and the otorrhoea remained.

In the course of a month after his departure from the hospital, the patient returned to the clinic, reporting an exacerbation of headache and vomiting. Bromides were given, and fomentations applied over the affected ear. In the course

of ten days there was a profuse hemorrhage from the ear, followed by cessation of pain and an increase in the purulent discharge. Numerous hemorrhages occurred in the course of the subsequent five days, and finally he became very weak and pale from loss of blood. Patient sank in five days, death being preceded by intense pain in the back of the head and down the neck to the shoulder on the right side, accompanied by some delirium.

The post-mortem examination revealed the following: "The temporal bone in the region of the middle ear had been changed into one large carious cavity, containing a sequestrum irregularly oblong in shape, one inch in length, and about seven lines in breadth and thickness." There was necrosis of the internal auditory canal, involving the auditory nerve. On removing the sequestrum, an opening was found in the carotid artery, the walls of which were softened. Opposite the internal meatus there was an abscess-cavity in the cerebellum, containing a drachm of dark, thin pus. "Adjacent to this, above and anteriorly, was a mass of cicatricial tissue, occupying the entire thickness of the gray matter, cut with difficulty, and presenting a discolored, uneven surface, probably the result of an abscess which had healed. The fourth ventricle contained an ounce or more of dark serum. On the superior surface of the cerebellum was a large discoloration, showing evidences of a former localized meningitis. The brain in all other respects was healthy."

It is maintained by the writer that there was no hope of relief in any operation in this case.

PISTOL-SHOT WOUND OF THE RIGHT MASTOID PROCESS.

Dr. Gorham Bacon, of New York City, gives an account of this rare accident, occurring in a woman 23 years old (Transactions of the American Otological Society, July 20, 1886). The wound occurred by the accidental discharge of a pistol six feet from the patient. The ball struck her just behind the ear and entered the mastoid process, being embedded in the cellules near the antrum. Four months after the accident the patient was etherized, and a sequestrum, which had found its way into the right auditory canal, was removed. An opening was made from the auditory canal into the mastoid cells, and

pieces of the bullet were removed; but, this opening not being large enough, the mastoid cortex was trephined. Some pieces of bone were removed through this opening in the mastoid, and the bullet was distinctly seen lying against the mastoid antrum. The operation was now interfered with by symptoms of collapse on the part of the patient.

In the course of two days the patient was again seen, and some traction made upon the bullet, but, as this caused pain and the patient would not be again etherized, all further attempts at removal of the bullet were stopped.

After treatment of the case as an outpatient for two weeks, it was observed that the mastoid wound was healing, the bullet remaining in the mastoid. The patient soon disappeared entirely from the clinic, and all trace of her was lost.

WOUND OF BOTH EARS BY PISTOL-SHOTS.

M. Rollin, interne of the Hôpital Bichat, gives an account of gunshot-wounds of both ears, occurring in the service of M. Terrier, as the result of an attempt at suicide in an insane man, 27 years old (*Annales des Maladies de l'Oreille*, December, 1886).

At the time of his admission to the hospital there was considerable hemorrhage from both ears. The patient was semi-comatose. Without any examination, both ears were plugged with iodoform gauze. The next day the temperature of the patient rose to 39° C. (102° F.), but in the course of a week fell to 37° C. (98° F.), and the patient became less dull. It was then found that deafness was absolute on both sides. There were soon observed symptoms of facial paralysis on the left side, which increased and became complete in the next few days, comprising the orbicularis palpebrarum, and demonstrating a lesion of the facial within the petrous pyramid. The cheek became flabby, the eye remained open during sleep, and mastication became difficult. In a month from his admission, an abscess formed above the right masseter muscle, in front of the auditory canal. The incision liberated a large quantity of thick, reddish pus. In the course of a few days, after the abscess had healed, a probe introduced into the right ear encountered a metallic substance two and a half centimetres from the opening of the canal.

Six weeks after the wound, the mental condition of the patient was a little better; the deafness, however, remained absolute, and trophic changes had begun in the left eye, on the paralyzed side. The eye became red and painful. His mental condition now grew very much worse, and, although continuing so, M. Terrier decided to undertake the extraction of the balls. The operation was performed somewhat over two months after the accident.

An incision was made, following the posterior auricular groove, and the auricle was loosened and drawn forward. The auditory canal was then cleared out and "scraped with a gouge, not without difficulty." The ball was then extracted, very much misshapen. Catgut sutures were then inserted, drainage of the auditory canal maintained, and the parts dressed with iodoform and carbolic acid. In a few days the wound healed. The general condition of the patient, however, became worse: he grew thinner, and the cornea of the left eye became uniformly opaque. He then became better in the course of a month, and remained so for a time, when suddenly his insanity grew worse. In about six weeks after the first operation it was decided to endeavor to extract the ball from the other side. The ball was found here at a depth of five centimetres.

The procedures were the same to reach the position of the bullet, though the hemorrhage was greater, in consequence of the deeper incisions necessitated by the depth of the ball. Some pieces were extracted, but when forcible traction was made upon the bullet a copious gush of bright red blood put an end to further interference, as it was supposed the hemorrhage came from the wounded internal carotid. Before resorting to ligation of the primitive carotid, M. Terrier made a firm tampon of iodoform gauze in the external auditory canal. After this the mental condition of the patient improved considerably, but this was only of short duration, and the case was placed in an asylum for the insane.

The left eye finally sloughed out; from the left ear a slight discharge still issued, and a probe encountered, at a depth of four centimetres, denuded bone and granulations.

The right ear healed entirely. The deafness on both sides remained absolute.

THE GYMNASIUM AS AN AID TO THE PHYSICIAN.

BY CHARLES MCINTIRE, JR., A.M., M.D.,

Lecturer on Hygiene and Medical Director of the Gymnasium, Lafayette College.

I HAVE no doubt that many of the readers of the *Times*, as they read the caption of this article, will recall *Punch's* suggestion that every foot-ball match be attended by an ambulance and a staff of surgeons, and will think of the possible fractures and more probable bruises. That would be of very material aid should they occur in one's practice. But these words are not used to convey such pleasantry. Indeed, definitely-prescribed exercise is the thought that is to be considered, whether it be had in or out of a gymnasium.

Experience is rapidly demonstrating—if it has not already done so—that there are many poorly-shaped, unequally-developed, and under-normal men (possibly women, too), besides others in whom there is not a proper harmony between blood and nerve, or brain and brawn; and that these people are continually breaking down, or using up, or are threatening to; and that the maladies expressing their condition are more difficult to cure because of this lack of harmony, or of some well-marked departure from a normal organism. There is a difficulty to secure the proper quality of blood, or to prevent excessive wear and tear,—not from any want of skill on the part of the physician, but from the condition of the patient himself. It is in this class of cases that the gymnasium frequently gives valuable assistance; in many cases as a prophylactic, in others directly as a curative agent. But when we speak of a gymnasium our minds must not at once picture double-trapeze acts, tumblings, and other feats of the circus-ring. These are unnecessary, often forbidden. We must think of the lighter instruments,—the pulley-weight of various kinds, and other apparatus adapted to the weakest, and capable of being used to exercise certain muscles and produce definite results. A man is blue from an attack of indigestion: "Fling but a stone, the giant dies," says Sterne; but hardly with truth. The stone may hurt him, but hardly despatch him. Slings as instruments of warfare are obsolete, and it is necessary to use something adapted to

modern habits. Let us plan and execute some means of exercise that will strengthen the abdominal muscles,—not neglecting other things, of course. We will thereby change the condition so that instead of feeling a soft, non-resistant, springless mass when the abdomen is touched, we will find firm muscular walls whose very touch is elastic and betokens strength; and in so doing you will, in many a case, change the condition of the parts under the abdominal walls, and a decided eupesia will have supplanted the former condition of dyspepsia.

In the use of gymnastic appliances it is necessary to study each case for itself. The gymnasium provides neither a panacea nor a specific; and there are many forms of exercise which, comparable to the old saw, "One man's food is another's poison," are often harmful to an individual, and should by all means be forbidden. Usually, however, our patients' sin in relation to exercise is one of omission, and not of commission: so that our duty more frequently is positively to direct the exercise to be taken, rather than forbid the use of any form of exercise. Thanks, however, to the workers in this field of study, we have learned that exercise is complex in character, and, when prescribed as a therapeutic measure, should be selected with as much care as is any drug. The use of a certain set of muscles alone will deform a well-built man; the use of that same set may be necessary to bring into harmony an unsymmetrical one. The point that it is desired to emphasize is, that telling a patient to take exercise, or a definite amount of exercise, is not enough, but we must prescribe its character as well; and, as in all remedial methods, we must be careful to have a very clear view of the end to be accomplished before we prescribe. The man who gives a prescription simply because it is said "to be good for" some disease will probably not find much good result from adding muscular movements to his list of remedies; but that one who studies out his cases and sees that it is desirable to obtain a definite result, which he thinks can be brought about by a certain line of treatment, will frequently find that definitely-prescribed exercise will be a great help. The use of Dyer's method of exercise in asthenopia will illustrate this, although it would not ordinarily be classed among gymnastic performances.

In our thoughts about exercise we must remember that the muscles are not alone acted upon, but the blood-vessels, nerves, and other tissues as well; and frequently we have here a valuable aid, enabling us to secure otherwise impossible results.

It might be inquired why such positive assurances are made of the excellent results to be obtained from the systematic use of exercise. The reasons are plain. There is, first, this departure from a normal standard of the individual, alluded to earlier in this article. Any one will accept the statement that there is a relation between the size, *e.g.*, of the lungs and the height of an individual which will permit the highest degree of health; and then it follows that any departure from this relation by so much prohibits the highest degree of health,—by a very small quantity, perhaps, but still by some quantity. Now, if in an individual this relation does not exist, and by your exercise you make the relation more nearly the normal one, you strengthen the individual; and what is said of the relation of lungs to height is also true of all the proportions of the body.

If any one desires to study this idea of a normal standard further, I would refer him to the writings of Dr. Nathan Allen, of Lowell, Massachusetts, who has very carefully and thoroughly presented many phases of the subject.

Selected exercise, then, brings man nearer his normal proportion. Then, again, there is comparatively little of this kind of exercise given; so that we have fallow ground to work upon, which will very probably yield us large and favorable results. The proof that too little developing exercise is taken lies in the fact that so many people are poorly developed. A fine-looking, well-developed man is a matter of observation and remark on our streets. And from the results obtained whenever developing exercise has been employed upon persons as ordinarily seen, it is fair to conclude that if such exercise were used to any great extent there would be more individuals seen who were well developed.

Of course, much of this aid to our profession will be in the line of preventive medicine,—probably the highest form to practise. By building up the proportion of strength and functions of the body to a normal, there will not only be fewer attacks of disease, but many forms of disease will be better resisted.

A statement made by Dr. Morgan in his "University Oars" is wellnigh worn threadbare by oft quotation, but so apt is it here that I venture to use it. In speaking of increasing the size of the chest, and thereby of the lung-capacity, if in an attack of pneumonia, "these additional fifty inches will amply suffice to turn the scale on the side of recovery. It assists a patient successfully to tide over the critical stage of his disease."

This exercise for development can be secured by free movements alone,—i.e., without any apparatus whatever; although some allege there must be some weight moved in order to cause exercise to avail for development. Without discussing this, it is certain that free movements can produce fatigue. One may, however, use dumb-bells or wands; a cane will do. Some one of the numerous forms of pulley-weights—any of these can be made useful; some are more convenient than others—will form one of the best means of procuring definite exercise, on account of the ease of directing the character of the movements. An expenditure of from five to six dollars or more will enable any one to set up an apparatus for muscle-development in their own home. The price of a dozen bottles of "Syrup of the Hypophosphites" or "Peptogenitic Elixirs," under any of their numerous aliases, will amply pay for one, be much more agreeable to take, and prove in most cases fully as efficacious, to say nothing of the greater value of the apparatus when compared with the empty bottles. Of course, when it is possible, it is better to send our patient to a gymnasium, where there are trained instructors and a variety of apparatus. We do not hesitate to consult the ophthalmologist or the neurologist: why should we hesitate to confer with the physician in charge of the properly-conducted gymnasium?

My experience during the three years since the opening of the gymnasium of Lafayette College, in the line of consultation and correspondence with various physicians concerning students who are or have been their patients, in order to arrive at a proper prescription for exercise, convinces me that a very respectable proportion of the profession are neglecting to inform themselves of a very important aid in combating disease; and because of this conviction, and in the hope that it will

cause some at least to give the subject the attention it deserves, this article was written.

EASTON, PA.

TRANSLATIONS.

ON THE PHOTOGENIC FUNCTION OF PODURIDES.—At a recent meeting of the Biological Society, M. Dubois communicated the following note on the photogenic function of podurides. The faculty of producing light, says the author, is more generally distributed among terrestrial animals than is generally supposed. Every one is now acquainted with the photogenic power of Lampyrides and Elaterides; it has also been detected in Myriapodes, but only by a few observers. On the contrary, there exists but one observation of this kind relative to Podurides, which is due to Professor Allman, and was published in 1850. That savant was the first to observe luminosity in the individuals of the species *Anurophorus fimetareus* (*Leptura fimetarea*, Linn.), in the month of February, on Howth Hill, near Dublin. They were profusely distributed in this place, and the thick piles of dung which were to be found here in great numbers were the only places where they were not to be seen.

Last October the author likewise found luminous podurides in precisely the same locality and at the same time in which he discovered the phosphorescent myriapodes which formed the subject of a preceding communication: that is to say, in the environs of Heidelberg, near the village of Handschuhsheim. In stirring up the humus in a hop-field, the author was surprised to find the soil covered with very little luminous stars, brilliant enough to be distinctly seen at a distance of about forty centimetres on a dark night (it was about nine o'clock in the evening). These little lights were so numerous in places that one might have easily imagined one's self on a beach whose sand was filled with noctiluces. An examination of a portion of the earth with an ordinary lens showed the presence of a small white insect, about three millimetres in length. Having selected a few individuals among the number and put them in a watch-glass, the author discovered that they possessed the faculty of emitting light, and that they

retained this faculty till death. Although the author was enabled to observe them during several consecutive days, he failed to discover the least sign of the localization of a luminous centre; the whole body of the insect appeared luminous.

Mechanical excitement, heat, and the agitation of the animal visibly augmented its photogenic power. In a general way, they offered the same physiological reactions as the other luminous beings previously observed. The light emitted was bluish, like that of the stars; but, for the want of an instrument, a spectroscopic examination could not be made. On crushing the insects upon a piece of litmus paper, it was plainly seen that the contents of the body were abundantly provided with luminous substance, which gave a manifest acid reaction. This point is important to note, because it establishes a fresh analogy between the luminous substance of pyrophores and of lampyrids; and, on the other hand, it constitutes an objection which no longer permits the acceptance of M. Radziewski's theory, since the photogenic reactions obtained by that chemist *in vitro* are produced only in an alkaline medium. The luminosity remained for several minutes on the paper where the insect had been crushed, even when wetted with a slightly acid liquid; while ammoniac vapor caused it to disappear immediately. When some of the crushed substance was placed upon the tongue, a manifest sensation of acidity was felt, together with a taste recalling that of certain mushrooms; the odor was similar to that of rotten wood and of the vegetable detritus wherein they lived.

These insects belong to the group of Podurides, and, although they resemble in some respects the *Lipura ambulans* of Lubbock and Tullberg, they should rather be regarded as belonging to the species *Lipura armata* (Tullb.), on account of the three ocellated points at the base of the antennæ. This peculiarity was observed by M. Gazagnaire in the entomological laboratory of the museum, while the author was only able to find two post-antennal ocellated points upon very similar individuals found in Paris, and which M. Gazagnaire considers as representing the species *Lipura ambulans* (Tullb.). In spite of the great similarity between the *Lipura ambulans* and the *Lipura armata*, the author was unable to discover the least

trace of luminosity in the latter species; but he does not consider the test as final, as he only observed them at the end of November.

A striking peculiarity in these insects is the fact that their bodies are filled with irregular lobes having great refracting power; and in polarized light, when the Nicol prisms are crossed, these lobes show that peculiar aspect which is observed in the luminous organs of pyrophores and lampyrids, and which is found in the digestive tube of luminous myriapodes. These lobes form, on the surface and on the sides of each ring, salient points, which have been taken for stigmata. Lubbock, on the contrary, considered them as adipose tissue. This also is the author's theory regarding them, in spite of the authority of Tullberg, who looked upon them as *systems of urinary canals*, "which seem to resemble the ramified glands of Malpighi in certain acari, but which differ from them in not having canals with an opening."

To these singular urinary canals without an opening Tullberg found an enveloping membrane, composed of two layers, one external, orchist, and the other internal, cellular, and precisely in this same *Lipura armata* which presented the phenomenon of luminosity. The author endeavored in vain, by means both of section and of dissociation, to discover this enveloping membrane composed of two layers; and, moreover, it was easy to see, by a simple examination of the preparations and by the figure given by Tullberg, that these parts, as well as the lobes, should be considered as adipose tissue. These lobes are composed of cells of the same nature; but those which are situated in the centre of the lobes are filled with rounded granulations, which Tullberg erroneously considers as urinary concretions. These granulations are not agglomerated in a canal, but in cells having an irregular contour, without an apparent membrane, and sometimes connected with one another by connective-tissue prolongation. These granulations and the cells which contain them are thoroughly comparable to those which are found in the luminous organs of pyrophores and of lampyrids, and the cellular wall of the pretended urinary canal is constituted by cells which as yet have no rounded granulations, and the nuclei may easily be distinguished after coloration.

Also, great importance should not be given to the presence of uric acid, which, according to Tullberg, had been observed by Professor Allman, because it is well known that almost all the parts of insects contain more or less of it. These granulations present peculiarities that are extremely curious. They have generally been considered as particles of urate of ammonia animated with Brownian movements. The author formerly considered them as unorganized particles containing guanine or a very similar substance; but more recent observations have caused him to change his opinion, and this will be the subject of a future communication.

INFLUENCE OF SOLAR RAYS UPON MICROBES.—At another meeting of the same society, M. Straus made a communication respecting the action of luminous rays upon microbes. M. Arloing has stated that the spores of the bacillus anthracis, placed in cultivations of broth and exposed to the sun, are destroyed; whereas vegetating mycelium resists a much longer exposure to the solar rays.

This fact is interesting if the resistance of these spores to all influences is borne in mind. MM. Nocard and Duclaux advanced the hypothesis that the solar rays acted much more upon the cultivation than upon the spores. M. Straus has confirmed this hypothesis in the following manner. The spores, placed in pure distilled water, resisted the action of the solar rays to which they were exposed for four hours; placed in broth, they were destroyed at the end of two hours.

M. Duclaux stated that he had observed, in some similar experiments he had made, that the period of two hours, which is sufficient to destroy young spores, is not sufficient to destroy spores two or three years old. M. Straus stated that his experiments were made with spores two or three months old. M. Duclaux's experiments were made with much older spores.

M. Chaveau added that spores of the bacillus anthracis when two or three months old can be considered young.

THE TREATMENT OF PHTHISIS BY INHALATIONS AND INJECTIONS OF CARBONIC ACID GAS.—Dr. Dupont, in a communication to the *Bulletin Général de Thérapeutique*, calls attention to the fact that Priestley first recommended the use of fixed air

by injection into the rectum as an "antiputrid agent." This method, however, is unpleasant, troublesome, and less rational than inhalation by the mouth, which possesses all the advantages with none of the drawbacks of gaseous lavements.

The advantages of this mode of treatment are (1) that carbonic acid is antiseptic, and is useful in overcoming the tubercular septicæmia; (2) it is anæsthetic, and quiets the cough; (3) it is a supplemental food, reducing oxidation and lowering temperature; and (4) it stimulates the digestive organs.

HELENINE IN DIPHTHERIA.—Helenine, obtained from the root of the elecampane, is a concrete, volatile, fatty substance, in white crystals of an aromatic odor and a bitter taste. It is insoluble in water, but soluble in alcohol and ether. Dr. Juan B. Obiol (*La Crónica Médica*), on account of the well-known antiseptic properties of helenine, has tried it in diphtheria. He applied powdered camphor to the patches of false membrane, and dressed with a solution of helenine in oil of sweet almonds. This treatment is aided by the administration of helenine internally in doses of a grain and a half for six-year-old children, being careful to avoid causing vomiting. The dressings must be made daily by the physician, and, when the disease is treated from the first appearance, twenty-four hours is generally sufficient to bring about a cure. At the end of five or six days of invasion, it will be necessary to continue the treatment for eight or nine days. Five or six days later the treatment ceases to be useful. Albuminuria does not occur: constipation is the rule.—*Nouveaux Remèdes*.

THE CARE OF THE SUBSCAPULAR NERVES IN REMOVING ENLARGED GLANDS FROM THE AXILLA.—Professor Kuster directs attention to the fact that, in cleaning out the axilla after extirpating a cancerous breast, great care should be taken not to injure the subscapular nerves supplying the subscapular muscle, the teres major, and the latissimus dorsi. He had seen cases where these nerves were injured, in which the movements of the arm were so restricted that the patient was unable to fasten her clothing. Since he has paid proper attention to the protection of these nerves he had not seen such results following the operation. — *Centralblatt für Chirurgie*, No. 11.

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EDITORIAL.

THE PERSONAL EQUATION IN
THERAPEUTICS.

THE temptation to become oracular upon the basis of one's personal experience has been an ever-present one to practitioners of medicine. The Scotch Professor of Anatomy who always referred to his personal peculiarities in order more forcibly to impress his lessons upon the attention of the students is by no means an isolated instance of this kind. The story is somewhat broad, but is happily characteristic of the type of medical man who sets up his own stomach and its propensities as the infallible guide to be followed in directing the dietary of his patients. A typical example of this kind, which might be termed the *argumentum e ventriculo suo*, is just now on its rounds in the medical press, to the effect that "Dr. — gives notes of a personal experience of nine weeks' illness from typhoid fever, during which he experienced a distinct aversion for food. He argues that this disinclination for food should be respected, and that nourishment should be given to fever-patients only when they call for it."

This opinion is attributed to an eminent Western surgeon and practitioner. While this may be regarded as correct doctrine in his own individual case, we decidedly dissent from the deduction that the experience is a proper guide for other physicians in all cases. One swallow does not make a summer;—neither is experience in one case a sufficient warrant for establishing a general rule which shall apply to every patient suffering with a certain form of disease. Since the day of Graves, the systematic feeding of fevers (often forced

feeding) has become a general practice, and, when intelligently followed out, has yielded most beneficial results. It was, in our estimation, one of the greatest merits of the late Professor Flint that he so strongly insisted in his writings upon the necessity of supplying proper and sufficient food in all cases of acute disease, without regard to the desires of the patient.

But the proposition which we would especially contest is that any one individual's stomach is a guide for all others. We know a physician who forbids apples, pears, and grapes to all his patients, even when convalescent, because, forsooth, he cannot eat them himself without hypogastric discomfort. Another thinks that eggs in any form must be injurious to the sick because he cannot digest them when well. Still another banishes milk from the dietary of his fever-patients, and would keep them alive on the only spoliative dietetic article known,—namely, beef-tea. In no other way perhaps is the influence of the personal equation shown more directly than in the various recommendations to patients with regard to the use of tea or coffee and alcoholic liquors.

Physicians frequently meet digestive idiosyncrasies in their practice. In fact, their existence long ago attracted popular attention, and became emphasized in the popular proverb, "What's one man's meat is another man's poison." These cases are not sufficient, however, to prevent the establishment of general rules of dietetics. Even the popular proverb quoted is erroneous when generally applied, for it is a fact that what is good for one is good for all as a general rule, to which, however, we must be prepared to find exceptions. Such a rule, in order to have practical value, should be established by a large series of experiences, and the verdict of the individual stomach, whether it belong to peer or to professor, should be rejected as a criterion in dietetics.

The problem of the digestibility of any article of food in any given case is to be decided by the capacity of the patient's stomach, and not by that of the physician, however authoritative or imperious its dictates in forming his own personal equation.

THE TYRANNY OF THE SCHOOL.

THE leading position in the April number of the *Popular Science Monthly* is given to an address delivered by Dr. William A. Hammond before the Nineteenth Century Club of New York, on "Brain-Forcing in Childhood." Dr. Hammond points out the great injury done by the cramming process to the undeveloped brains of young children, and then shows the absurdity of many of the studies with which school-children, especially girls, are burdened. He animadverts upon the mistake of giving children too many subjects to study at the same time, and illustrates the point by referring to the bad effects of "cramming" as indulged in by medical students. He says, "I speak from personal experience when I say that I am aware of the most lamentable results of the 'cramming' process in medical students. I have been a teacher in medical schools for nearly twenty-five years. In the course of my examinations it has often happened that I have put a question in one branch of medicine to a candidate for graduation and have received an answer in an entirely different branch."

The absurdity of the answers sometimes given by medical students during the final examinations would be amusing if it were not so frequently an evidence of the pernicious methods to which Dr. Hammond here refers. This is exemplified in almost every examination of students for the medical degree.

We entirely agree with Dr. Hammond in his scathing denunciation of grammar as a subject of study in schools. We would willingly see it "banished from

all schools," and would not even except, as he does with a reservation, "the senior year of a university course." No child, he truly says, "ever learned to speak good English from studying grammar. It has driven many a poor little wretch into headaches and other nervous troubles. It is the most ingenious device for forcing an immature brain into early decrepitude that the cunning of man has yet devised. The only reason why it does not do more harm is that not one in ten of the pupils that come out of our schools know anything about it."

In addition to grammar, we would like to banish from all schools that "idiotism" called "mental philosophy," which no sane boy or girl ever can comprehend; and, from girls' schools especially, geometry and trigonometry, which not one in five hundred understands, and not one in ten thousand has any use for in after-life.

We do not plead for a grossly utilitarian scheme of studies in the schools. That would be equally absurd with the present system. But, as professional men, conversant with the evils to physical and mental health which characterize our present public school methods; as citizens, interested in the highest development of the men and women who shall represent our national life; and as parents, solicitous for the well-being of our offspring, we have a right to demand that school boards and teachers shall heed our warnings. Among physicians and students of hygiene this question has been long discussed and reforms agitated. Dr. Hammond has preached his lay sermon to a wider congregation. Let us hope that his exhortation will bring those in fault to an early repentance.

ARCHIBALD MALMAISON has a counterpart in real life. A preacher, sixty years of age, left his New England home, settled in Norristown, Pennsylvania, and went into business. Six weeks later, consciousness of his identity suddenly returned to him. A further account of this will appear shortly.

NOTES FROM SPECIAL CORRESPONDENTS.

PARIS.

TREATMENT of Pleurisy in Paris.—A recent clinic of Professor Jaccoud's and a long discussion at the Société Médicale des Hôpitaux upon the treatment of pleurisy permit us to communicate the ideas of prominent medical men here with regard to this disease in its different manifestations. Professor Jaccoud spoke of the "Indications for Thoracentesis in Acute Pleuritis." He presented two patients, and instituted different treatment in each one. The patients were both wagon-drivers, one aged 30 and the other 40, and both had had apparently good health up to the present attack of acute pleurisy with considerable effusion. One of them had entered on the eleventh day and the other on the sixteenth day of illness. In both of them signs were found of tubercular alteration at the summit of the lungs, and therefore the prognosis was not very favorable as to ultimate results. The only apparent difference between them was that No. 29 had slight fever, and in No. 12 the disorder was apyretic. Then as to the quantity of liquid there was a difference. The effusion in No. 29 was already large when he entered, and it continued to increase almost under the eyes of the attendants, filling the pleural cavity to completion, as the percussion-sounds showed; while in No. 12 the liquid did not occupy more than the inferior two-thirds of the thoracic cavity; but it was on him that Dr. Jaccoud practised thoracentesis, while abstaining from doing so on the other patient. The only reason he gave at the time was that one was a right pleurisy and the other a left; but now he explains his action as follows: "It must be always remembered that dyspnoea is not the only indication for thoracentesis. Certainly it is a very important one when it exists, and when caused by the effusion; but there are plenty of patients, like these two, who have no dyspnoea at all, and a particular interest resides in such cases as regards the opportunity of paracentesis. First of all, the side must be taken into account. In right pleurisies there is no immediate danger, as a rule, and, if the febrile process has not ceased, internal medication can be tried with a fair promise of success; but if the patient be not seen until it is too late,—that is, when all the febrile disturbance is over,—then nothing can be hoped for from medicine, and aspiration becomes obligatory at once. In left-sided cases of effusion, without dyspnoea, the principal point is to notice the quantity of the liquid and the displacement of the heart and other organs; the functional symptoms are not of so much account. If the patient has arrived at the apyretic stage, and there is no

displacement of the heart or liver, then wait; and this is why the therapeutics differed in the two cases. In No. 12 the indication was to operate at once. The effusion occupied two-thirds of the cavity, but the heart was displaced to the right at least two fingers' width from the right sternal side.

"However, notwithstanding these practical rules, if you have a doubt about this matter, always practise thoracentesis in any given case; because, when properly performed, it is always an innocent operation. But do not forget the precautions that Professor Dieulafoy often speaks about: which are, *never to empty the pleural cavity entirely*, nor allow the liquid to flow out too quickly. Give time for the lung to expand, and stop if the cough becomes too fatiguing; because it may be caused by the influence of the air compressing the lung. This is the indication to stop the discharge of fluid; but, as a rule, the quantity should not be over twelve to thirteen hundred grammes (over a quart). The classic precept given is to make the puncture in the axillary region; but this must vary with the patient, and it should be practised in the region where there is the greatest effusion. The second patient, who was not aspirated, was submitted to the tartar-emetic treatment, with drastic purgatives, and from the administration of thirty grammes of the *Eau de Vie Allemande* (a tincture of jalap and scammony) and thirty grammes of syrup of buckthorn (*Rhamnus catharticus*) he rapidly improved."

The case presented for the consideration of the Medical Society was one of M. Debove's, which he called *latent purulent pleurisy*, and a discussion took place about the treatment of such cases. M. Debove himself said that the patient was a man of about 30, who had been ill for six months, more or less, before he came to the hospital, but his malady did not prevent him from working. Upon examination, a considerable effusion was found on the left side, with displacement of the heart. He was aspirated, and a quart of liquid of a sero-purulent nature taken away on several occasions, with the result that it came back again. He was then let alone, this time for two years, and engaged in light work about the wards. He suffered some, and his digestion was bad, but still he was in passable health, and Dr. Debove thought best to abstain from all treatment, and he asked the opinion of his fellow-members with regard to the management of these cases of latent pleurisy, which had been described by De Mussy and Dieulafoy.

Dr. Rendu, of the Necker Hospital, and Dr. Bucquoy, of the Hôtel-Dieu, thought that in such a case it was well to commence by successive operations and allow the lung to dilate, and then, when the pleural cavity was small enough, practise an empyema operation, to be followed by Estlander's operation

or not, according to the indication. Dr. Dumontpallier said he was not a partisan of aspiration,—that might be repeated forever; but that as soon as an effusion was shown to be purulent he would advise large incision under antiseptic methods. He was not at all in favor of aspirating instruments, but thought the puncture should be made with an ordinary canula, so that it would be the elasticity of the lung alone that would push the liquid out: as it expanded, this and the movement of the thoracic cage would be enough to make the liquid flow out as the lung filled up. He was of the opinion that great harm might be done by sudden aspiration.

M. Debove and others concluded that, after the poor success they had seen from paracentesis, it would be best to abstain unless danger from asphyxia was present.

On the Action of Opium and Belladonna associated in a Case of Acute Diabetes.—M. Villemain, who is the Professor of Medicine at the Val de Grâce (military) Hospital here, communicates to the Académie des Sciences an interesting article on the above subject. He says "that he had lately a therapeutic fact that was as precise and as clear as any physiological experiment. It was that of a young artilleryman of strong constitution, who was admitted with acute diabetes with all its usual symptoms, consisting of a polyuria of fourteen litres a day, and discharging eight hundred and forty-one grammes of glucose in the same period. The usual treatment was at once commenced by ordering abstinence from sugar, etc., and giving meat-diet with the gluten bread, etc.; but, a week having passed without any improvement, Dr. Villemain thought of a case of diabetes insipidus that he had seen cured with belladonna and opium, and began to try it in this man. He feared at first that he might provoke an accumulation of glucose in the system by putting a check on the urinary secretion by this medication. But, however, he began by giving ten centigrammes of extract of belladonna and five centigrammes of opium extract per day; and seven days afterwards the urine had gone down to ten litres, and the sugar to four hundred and ten grammes. He then progressively increased the dose, and at the end of two months got up to fifteen centigrammes of each medicine, when he had the satisfaction of seeing the urine and the sugar eliminated diminish gradually. At this time the urine was from three to four litres, and sugar two to five grammes per litre, and the dose of the medicines was raised to twenty centigrammes, when, a week afterwards, there was not the slightest sign of sugar.

M. Villemain then suppressed all drugs, and in two or three days the sugar came back, so he was forced to return to the same dose, when, five days later, the sugar had again disappeared and the quantity of urine was

now two litres. The cure was maintained as long as the medicine was continued; but the moment the dose was lowered or stopped, the sugar would reappear and the urine increase in quantity. During all this period of experimentation the patient was kept on the usual diet; but this was now changed, and he was permitted to use all kinds of food as he liked, or what was given to the healthy men. But this did not make any difference as long as the dose of twenty centigrammes was kept up. Later bromide of potassium was tried; but the sugar returned and the urine increased to eleven litres. Experiments were also made, by giving one only of the medicines, to see if either of them had a preponderating action or an exclusive one in modifying the disease, and it was seen that the results obtained were by the association of the opium and the belladonna.

Contagion in Febrile Exanthemata.—Most writers are silent on the point as to the exact moment when the eruptive fevers are contagious, and the general public opinion is that they are all catching during the period of convalescence. Dr. Girard, of Marseilles, says this idea must have come from physicians originally, as the people get all their medical ideas first from the doctors, directly or indirectly. He himself had held this notion; but, after a careful study of the matter in some one hundred and fifteen cases, first he found that it was the reverse of true, and, following up the subject for some years, he cites a large number of facts to prove that *contagion in these fevers always takes place at the very beginning of the disease*, and he found that the incubation takes, as a rule, fourteen days. Cases are given of varicella, measles, and smallpox to prove this statement.

Dr. Girard now tells his patients, when they want to send their other children who may not be attacked out to the country, "No; it is useless. If they are to have it, they have got it already from the one who is ill." In regard to measles, he also does not believe that children get it a second time, for it will be found, on examination of such attacks, that the eruption is not the same, the marks are not of the characteristic half-moon shape, nor are the usual oculo-nasal catarrh symptoms found in such cases. He gives a very striking case to prove that contagion takes place at the beginning: it was a family who had several children ill with varicella, and the pustules were not yet dry, when a relation having two healthy children arrived on a visit. The doctor was asked his advice, and, being firmly persuaded that the disease was only catching at first, he permitted the children to remain and play with the others without the slightest danger to them, or either of them, taking the complaint. This is, of course, a negative fact, but, taken as coming after a

large number of very positive ones, it seems to confirm the idea that these fevers are contagious from the first.

Treatment of Neuralgic Sore Throat.—

Most practitioners of medicine have frequently noticed, upon inspecting a supposed sore throat, that, much to their astonishment, there was but very slight redness of the fauces, and that it could not in any way account for the painful sensations described by the patients. Dr. Huchard says that these cases are not inflammatory angina at all, as the pain is not owing to the inflammation itself, but they are what he calls "neuralgic angina." These cases are similar to those congestions or slight uterine hemorrhages that are associated with lumbo-abdominal neuralgia, or those ocular hyperæmias that are provoked or at least kept up by facial neuralgias. The following are the clinical characters that will enable us to diagnose them: 1st. An entire discordance between the pain and the superficial inflammation of the tonsils, etc. 2d. Entire subordination of the hyperæmia to the neuralgic symptoms, which last precedes all inflammation and often survives it. 3d. The character of the pain is not continuous, but manifests itself by paroxysms, which take place apart from deglutition, and increase at night. It is also very rarely isolated, but has other neuralgias (facial, occipital, cervical, etc.) at the same time, and it is frequently complicated with otalgia, which is much more violent than in other inflammatory forms,—when seen with tonsillitis, for instance. These pains are frequently so violent that one is disposed to think of meningitis.

These clinical facts command the following therapeutic indications. The treatment must be directed more against the neuralgic element than against the congestive one: so that all emollients and antiphlogistic remedies are useless. To fulfil the pathogenic indication, Dr. Huchard advises the following antiperiodic and antineuralgic medicines:

R Quinina sulphatis, 20 centigrm.;

Ext. aconiti radices, 1 centigrm. M.

Fiat pil. (one). Sig.—Give three such pills, at an hour's interval, in the morning. When the neuralgic pains are very intense, give a cachet of hydrobromate of quinine, twenty-five centigrammes, in which put a granule of aconitine of one-quarter milligramme size, and give it three times a day.

As to local treatment, order the pharynx to be touched two to four times a day with a little of the following mixture on a brush:

R Glycerini (puri), 10 grm.;

Morphinæ hydrochloratis, 10 centigrm.

Aquæ menthæ piperitæ, 4 gtt. M.

The peppermint acts by its "antalgic" properties, as shown by Delieux de Savignac and others.

In all very painful sore throats accompa-

nied by spasmodic cough, the following formula may be used locally in the same way:

R Glycerini (neutral),

Aquæ menthæ piperitæ, 33 10 grm.;

Potassii bromidi, 5 grm.;

Cocainæ hydrochloratis, 50 centigrm. M.

Sig.—Paint on part as required.

Flatulent Dyspepsia.—Before closing Dr. Huchard's prescriptions, we would like to give one that he gives very often in the above disorder when it is the pure atonic form, without acidity or heartburn, but simply discomfort, pain, and flatulency. His idea is that there is present a decomposing fermentation, and therefore the indication is the anti-ferments:

R Aquæ aurantii florum, 100 grm.;

Aquæ melissæ, 50 grm.;

Aquæ chloroformi (saturated), 100 grm.

M. Sig.—Take a dessertspoonful before each meal.

About the middle of each meal take a glass of oxygen-water. The oxygen-water ordered is now manufactured in Paris by a firm who have a process for making oxygen gas, and they deliver it in siphons, like the familiar ones seen in all the hotels and restaurants and supposed to contain seltzer water.

The writer strongly advises the use of the above formula, as he has seen great benefit from it in a number of cases of flatulent dyspepsia. The oxygen-water might be replaced by some natural spring water with but little gas in it.

Paris Hospital Therapeutics.—It may be useful to give in a short way, as complete as possible, the kind of medicinal treatment employed in the hospitals, and we take the service of Professor Germain Sée as a guide. The following is from the official book of the Salle (or Ward) St. Jeanne, Hôtel-Dieu:

RED.	DIAGNOSIS.	TREATMENT.
1.—Anæmia.....	Hemoglobine and pepsin.	
2.—Chlorosis.....	Sodii arsenias.	
3.—Zona.....	Antipyrine, 4 grammes.	
5.—Hemiplegia.....	Todd's potion.	
9.—Peri-uterine phlegmon.....	Injections, terpine, nux vomica, and gentian.	
12.—Syphilis, cerebral.....	Binioidide of mercury, sulphur-baths.	
12 (bis).—Chlorosis.....	Ferri et potassii tart., sulphate of aconitine.	
14.—Albuminuria.....	Tannin pill, ergotin pill, terpine pill.	
14 (bis).—Mitral insufficiency...	Sparteine sulph., convallamarin.	
15.—Pericarditis and aortic ret.	Iodide of potass., digital, sparteine.	
18.—Myocarditis.....	Caffeine, sparteine.	
20.—Thoracic varix.....	Tinct. hamamelis, antipyrine, Vichy water.	
22.—Typhoid fever.....	Charcoal powder, naphthaline, quinine sulph., rectal injections.	
23.—Amyotrophia.....	Pill opium, mercurial frictions.	
24.—Mitral insufficiency.....	Digitalis infusion.	
25.—Dyspepsia.....	Charcoal powder, benzoate of soda, terpine.	
26.—Diabetes.....	M. Sée's régime, arsenic.	
27.—Hydroarthrosis.....	Antipyrine.	

BED.	DIAGNOSIS.	TREATMENT.
28.—Phthisis.....		Arsenic, pill opium.
29.—Dilatation stomach.....		Ipecac powder (5 centigrms.), cocaine hydrochl. (5 centigrms.); suppress all vegetables.
29 (bis).—Not made.....		Jalap.
30.—Emphysema.....		Terpine, iodide of potassium, pill opium, sparteine sulphate.

Of course, in this rapid list of actual patients and treatment we have not time to indicate the symptoms for which some of the remedies were given; but those accustomed to hospital practice will see the reasons and be able to compare the above with their own practice.

More Changes at the Paris Faculty.—You will probably have already noticed the death of Professor Bécларd, the eminent physiologist, who was dean of the Paris Faculty. He had gone to a dinner given in honor of the nomination of Professor Farabeuf to the chair of Anatomy, and returned walking, with the result of being carried off in nine days with pneumonia. The regretted professor will most likely be replaced as Professor of Physiology by Professor (*agrégé*) Ch. Richet, who is the son of Professor Richet who holds one of the chairs of clinical surgery at the Hôtel-Dieu. The position of dean will probably be given to Professor Brouardel, who is the Professor of Legal Medicine at the Faculty, and whose name is connected with all the medico-legal cases in Paris. He will receive three nominations at once shortly: one to the Academy, one as dean, and one as physician to the Hôtel-Dieu in place of Dr. Gallard,* who died lately. M. Brouardel is still in the prime of life, and he is a most eloquent speaker, attracting the largest audiences at his lectures at the Faculty. He is also a very amiable man, with great influence in the world of science and politics, so that this, combined with his thorough knowledge of his functions, will make him a great acquisition to the Paris Faculty as their dean.

THOMAS LINN, M.D.

PARIS, February 23, 1887.

WASHINGTON.

THE INTERNATIONAL MEDICAL CONGRESS: DISTINGUISHED VISITORS EXPECTED—THE MEMORIAL TO SURGEON AMBLER—SURGEON-GENERAL MOORE AND SECRETARY ENDICOTT—THE YELLOW FEVER INVESTIGATION.

WASHINGTON, March 22, 1887.

THE preparations for the Ninth International Medical Congress are being pushed with energy by the several local sub-committees. The Sundry Civil Bill, as finally passed,

* Dr. Brouardel will not, however, take Dr. Gallard's service, of women's diseases, but one of medicine.

appropriates ten thousand dollars towards defraying the expenses of the Congress. The Senate had adopted an amendment appropriating thirty-five thousand dollars, but a member of the House Appropriations Committee is said to have threatened the defeat of the entire appropriation unless the reduced sum was accepted by the Senate conferees. The bill contains a provision that the sum appropriated shall be expended only on vouchers approved by the Secretary of the Interior.

This amount, while of material assistance, is totally insufficient to cover the extraordinary expenses incident to the Congress. Hence it will be necessary for the profession to respond promptly and liberally to any appeals that may be made by the Executive Committee for funds for the entertainment of the foreign guests who are expected.

The scientific success of the Congress is no longer in doubt. Of the large number of foreign delegates who have accepted invitations and signified their intention of being present, the more prominent are the following:

Drs. E. Landolt, A. Chervin, Dujardin-Beaumetz, M. Magitot, P. Mérieux, W. D. Hogg, A. Charpentier, J. Amédée Doléris, Marquis Nadaillac, B. Löwenberg, Léon Petit, Victor Audhui, Henri Picard, P. Budin, M. Durand-Fardel, P. de Pietra Santa, and H. Leloir, of France.

Surgeon-General Jeffry Marston, John A. Macdonald, Dr. Evatt, Sir William Alexander Mackinnon, Sir Thomas Longmore, Sir James A. Hanbury, F. Bowreman Jessett, Urban Pritchard, J. H. Galton, J. Jamieson, Alexander Russell Simpson, F. P. Staples, John Anderson, A. Watson, Joseph Ewart, Dr. Lofthouse, E. H. Roberts, Alfred Pearce Gould, W. Allan Jamieson, William MacEwen, Isambard Owen, C. D. F. Phillips, J. G. S. Coghill, Ralph Stockman, William Murrell, Sidney Martin, Edmonston Charles, P. A. Young, Alfred L. Galabin, T. Colcott Fox, George Thin, Jonathan Hutchinson, M. Ludlow Purves, F. M. Pierce, J. J. Kirk Duncan, R. N. Wolfenden, John Sutliff, Dudley W. Buxton, John Hutchinson, George Johnson, Sir E. H. Sieveking, S. A. M. Gordon, A. T. H. Waters, Walter Pye, William Frazer, Arthur Mitchell, M. Julius Mickle, H. Charlton Bastian, John Simon, David Ferrier, W. A. Brailey, Henry Power, J. William Moore, D. Hack Tuke, J. Syer Bristowe, W. Howship Dickinson, P. H. Pye Smith, C. Macnamara, J. W. Hulke, Christopher Heath, Richard Barwell, William Anderson, Thomas Bryant, Edmund Owen, Arthur W. Orwin, George H. Savage, W. M. Whitmarsh, J. William Taylor, Thomas More Madden, Robert Gray, McCall Anderson, Eustace Smith, Charles West, T. M. Dolan, J. W. S. Thudichum, Benjamin W. Richardson, J. Comyns Leach, H. B. Hewetson, George Gray, Julius Althaus, Lawson Tait, Sir J. Crichton Browne,

W. Dunnett Spanton, and E. Radcliffe Cousins, of Great Britain.

Drs. A. Hegar, Christian Bäumler, A. Gussow, Joh. Veit, A. Oldendorff, F. Winckel, A. Wernich, L. Lewin, P. G. Unna, O. Lassar, Surgeon-General Von Coler, F. Esmarch, Dr. Schwartz, and A. Eulenburg, of Germany.

Dr. Leopold Servais (official representative of the Belgian government), Professor Hauben, and Dr. Alfred Struebens, of Belgium.

Dr. O. Chiari, Gustav Braun, Emil Ehrendorfer, Alois Monti, H. Widerhofer, E. H. Kisch, Joseph Körösi, Moriz Kaposi, Hans von Hebra, Isidor Neumann, Johann Schnitzler, Dr. Neudörfer, of Austro-Hungary.

Drs. A. Cordes and F. Dumont, of Switzerland.

Professors J. W. R. Filanus, A. Guye, and Dr. Gori, of Holland.

Drs. Domenico Chiara, W. W. Baldwin, Andrea Ceccherelli, Luigi Casati, Eugenio Fazio, and Domenico Peruzzi, of Italy.

Professor Hirschsprung, of Denmark.

Dr. Miguel Gonzalez Gonalsey, of Spain.

J. A. S. Grant (Bey), of Egypt.

Dr. Leonard Boor, of New Zealand.

Dr. Moncorvo, of Brazil.

Dr. H. Reimann, of Russia.

Professor T. W. Kay, of Beyrout, Syria.

This list of names looks sufficiently international, and most of them are pretty well known to students of current medical literature. It is true we shall probably not be able to get Bismarck, Boulanger, Schwenninger, or Señor Ferran, because we cannot promise that they will meet "the leaders of professional thought"—certain able editors and their assistant kickers in Boston, New York, Philadelphia, and Baltimore—at the Congress. On account of a change in administration, both of the country and of the Congress, we shall not be able to pay the travelling expenses of the foreign delegates. This may keep some of the very prominent ones at home. All those that come, however, will find a hearty American greeting awaiting them, and during Congress week, at all events, the latch-string will hang outside.

The Committee on Entertainment is actively engaged in preparations for the entertainment of the distinguished guests. No one need fear that the social features of the Congress will be neglected.

The Committee of Arrangements has secured the following places of meeting for the Congress and the various sections.

The general meetings and the sessions of the Sections on General Medicine and on Dental and Oral Surgery will be held in Albaugh's Theatre.

The Sections on General Surgery, Military and Naval Surgery, and Dermatology and Syphilis, in Cornwell's Building, Pennsylvania Avenue.

The Sections on Anatomy and Pathology, in the Army Medical Museum.

The Section on Physiology, in the United States National Museum.

The Sections on Obstetrics and Gynecology, in the Georgetown Medical College.

The Sections on Materia Medica and Therapeutics, and Psychological Medicine, in the National Medical College.

The Sections on Medical Climatology and Dermography, and Public and International Hygiene, in the Masonic Temple.

The Sections on Otology, Laryngology, and Ophthalmology, in Columbia Medical College.

The Section on Diseases of Children, in Willard's Hall. This will also be the headquarters of the local committees and the place of registration.

The rates at all the principal hotels have been reduced to three dollars and three dollars and a half per day.

The medical officers of the navy have just had completed a beautiful tablet in bronze, commemorative of the heroism of Surgeon J. M. Ambler, who perished with De Long and his companions in the *Lena Delta* in 1881. It will be remembered that when the "Jeannette" was crushed in the ice and sank in June, 1881, the exploring party took to the three boats, and that two of the latter reached land in the *Lena Delta* on September 16 and 17. The third boat, containing Lieutenant Chipp and seven men, was lost, no trace of it ever having been found. Reduced by cold, disease, and starvation, those who had escaped the sea searched for their missing companions, but without success. Lieutenant Danenhower and Engineer Melville, with nine others, succeeded in reaching home after undergoing many privations. The captain's party consisted of fourteen, including Dr. Ambler and Mr. Collins, the meteorologist (a brother of Dr. Collins, of Minneapolis). Of these, only two seamen, Nindermann and Noros, who had been sent ahead for assistance, escaped. The others, worn out and hopeless, "fell down and died as they walked along," Captain De Long, Dr. Ambler, and a Chinaman, Ah Sam, being the last to succumb.

The tablet, which is of bronze, encased in a heavy oak frame, illustrates in a very spirited manner a scene on the 9th of October, 1881, when Nindermann and Noros are leaving the camp for succor. At this time the party were living on three ounces of alcohol per day, with no solid food whatever. The captain urged Dr. Ambler to accompany them and try to save himself; but the latter declined, saying his duty was with the sick and dying. Besides this representation, the tablet contains an oval medallion bearing an excellent likeness of Dr. Ambler, and his name and rank, with the legend, "Duty stronger than love of life," in decorative lettering.

The entire memorial is gotten up with ex-

cellent artistic taste. The conception and execution in all details are exceedingly creditable to the committee having the matter in charge and the artists, Messrs. Joseph Lauber and Charles R. Lamb, of New York. The tablet is now on exhibition at the Corcoran Art Gallery. It should be photographed under the auspices of the committee, in order that every one who desires may have a representation of this beautiful and characteristic memorial, which typifies in such an exquisite and impressive manner the qualities which all men honor.

The reported disagreement between Surgeon-General Moore and the Secretary of War has been much exaggerated in the newspapers. While there are reasons for believing that Dr. Moore was at first annoyed and offended over the apparent interference in the management of his office by the Secretary, it may be confidently stated that no resignations or retirements will follow as a consequence. Dr. Huntington was relieved from duty in the Surgeon-General's Office in pursuance of the principle established long ago by Secretary Endicott, that officers shall not remain on duty in Washington longer than four years if others can be found to perform their duties satisfactorily. Dr. Huntington had been for about sixteen years continuously on duty in the Surgeon-General's Office, and was granted a change of station. It is probable that other changes of a like character will soon be made.

A great deal of gossip is current with regard to the influence of Dr. Baxter in securing the changes that have been made, but there is nothing in the rumors. While Dr. Baxter is credited with having a good deal of influence with the Secretary of War, he is not the sort of man to use it unfairly.

The sum of ten thousand dollars has been appropriated by Congress to pay the expenses of an investigation into the alleged protective inoculations against yellow fever claimed by Dr. Domingos Freire, of Brazil, and Dr. Carmona, of Mexico. A large number of inoculations have been made in Rio de Janeiro and other cities in Brazil, and the results are said to substantiate fully the claims of Dr. Freire. An investigator with good judgment and thoroughly competent to perform the duty should be selected for this mission. It is generally believed that the choice will fall upon a distinguished medical officer of the army who is *facile princeps* in the department of bacteriology. The President may decide, however, that no special bacteriological knowledge is necessary in order to accomplish the purposes contemplated by the Act of Congress, and appoint some one else. It is said that among the applicants for the appointment is Dr. Joseph Jones, formerly President of the State Board of Health of

Louisiana. Dr. Jones has had much personal experience with yellow fever, but his selection for the proposed investigation would not inspire much confidence among the members of the profession who look forward with interest to the solution of such a vitally important problem as the prevention of the most destructive scourge that constantly threatens our Southern border.

G. H. R.

PROCEEDINGS OF SOCIETIES.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

THURSDAY, MARCH 3, 1887.

The President, THOMAS M. DRYSDALE, M.D., in the chair.

DR. E. LONGAKER read a paper on

TREATMENT OF LABOR IN CONTRACTED Pelves.*

The most frequent forms of contracted pelves are the flattened and the generally contracted. In the former the conjugate diameters alone are shortened, and in the latter all are less than normal. The paper was limited to the consideration of those cases where the narrowing is moderate and not sufficient to render the birth of a living child impossible. This embraces flat pelves having a conjugate of three inches or a little less, and generally contracted pelves having a conjugate of at least three and one-third inches.

Dr. Longaker here followed with a description of the peculiarities of the flat non-rachitic pelvis and the flat rachitic pelvis.

Reports of six cases were given. In Case 1, with a conjugate of three and one-half inches, craniotomy was performed, in consequence of the large size of the head and an unchangeable bad presentation of the head, after attempts to deliver with the forceps had failed. The mother ultimately recovered. A careful study of the change from a vertex- to a brow-presentation was followed by comments on the increased dangers in multiparæ, with a criticism on powerful traction efforts, first with one pair of forceps and then another, until three or four have been tried.

Case 2 was delivered with forceps of a living child.

Case 3 was also delivered with forceps of a living child.

Case 4. Rachitic flat pelvis, conjugate of three inches, second pregnancy, delivered by means of Tarnier's traction-forceps. Her first child had been born without assistance, after sixty hours of labor. A large portion of the posterior cervix had sloughed away as the result of this prolonged labor. The head

* Published in the American Journal of Obstetrics.

was transverse and semiflexed at the superior strait. He applied the forceps over the face and occiput, and delivered a living child. The mother did well.

Case 5 was a counterpart of the fourth. Tarnier's forceps were used, and mother and child did well. With version in contracted pelvis he has had no experience. Under favorable circumstances, the operation can be done so easily that it may be regarded as without danger in itself.

Case 6 was a breech-presentation in a contracted pelvis, third pregnancy. The first child had been stillborn, the second was delivered alive by means of forceps. In this, the third labor, the extraction of the after-coming head was very difficult, and the child was still. The day after delivery, signs of internal hemorrhage and peritonitis appeared, and the mother died twenty-four hours after delivery. Rupture of the uterus and vagina was found at the autopsy.

Three other cases of uterine lacerations in breech-presentation in contracted pelvis were given, followed by a study of the mechanism of this tendency to laceration. He came to the conclusion that it will be best to restrict version to cases in which there are other reasons for it than the mere existence of flattening,—some of these being the presence of the occiput on the smaller side of an unequally-contracted pelvis, the sagittal suture over the symphysis pubis, presentation of an ear, and prolapse of the cord. He extolled the axis-traction forceps in these cases, and exhibited an instrument of his own devising, which he had used in two cases. He has no hesitation in applying the forceps high up in the uterus when the head is arrested at the brim of the pelvis, and cited fifteen cases of such application in proof of his opinion. After some remarks on estimation of the conjugate diameter, he concluded with the following propositions:

In the flat pelvis and in the flat rachitic pelvis, decided degrees of disproportion at the brim may be overcome by the natural efforts when the head presents.

In the forceps, and especially in the axis-traction forceps, we have the means of extending still further the possibilities of successful delivery when the head is arrested at the brim.

The forceps, judiciously used, is a safe instrument for mother and child.

The existence of contraction of the pelvis in itself is no reason for preferring version.

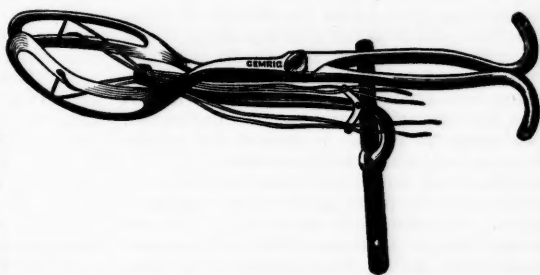
In flat pelvis, with a conjugate diameter of not more than three and a fourth inches and not less than two and three-fourths inches, premature labor should be induced.

Dr. HIRST differs from Dr. Longaker on two points: the propriety of always apply-

ing the forceps in flat pelvis before the head has become engaged, instead of turning and delivering by the breech; and the propriety of applying the forceps over face and occiput in transverse positions of vertex-presentations, as in this latter operation the biparietal diameter must be increased.

Dr. H. A. KELLY agreed with Dr. Hirst. He considered the paper of Dr. Longaker a very timely one, which in all its leading features he most heartily commended. It is certain that an intelligent use of the axis-traction principle is destined to revolutionize the treatment of labor in contracted pelvis. In cases in which craniotomy has been the custom, axis-traction will save many lives. A few important rules should be borne in mind. First of all, Dr. Kelly would differ from the speaker most decidedly in one practice, and lay down the rule that "axis-traction" cannot be applied to the head above the brim. There is no axis above the brim, and any traction on the rod merely causes the head to rotate around its own axis, but can under no circumstances be efficient in inducing it to engage. Axis-traction applies to heads engaged in the pelvis. Again, the ordinary use of this principle should be to *assist the pains*. Further, it is important in using Tarnier's forceps of this model to attend constantly to keeping parallel the shanks of the prehensile blades and the proximal end of the traction-rod.

If the handles of the forceps rise during a traction, and it is felt by the examining finger that the head has not really advanced, then either the head has rotated in consequence of an eccentric grip or the forceps has slipped; and here lies the great difficulty of the Tarnier instrument. The frequency of this acci-



dent, together with some other considerations regarding the mechanical construction of the instrument, had demonstrated to his mind the fact that it is only approximately axis-traction. He showed a pair of forceps (see illustration) with which he had delivered a dwarfed woman of a full-sized, live, female child through a three-inch conjugate. This pair of forceps was shown him first by Dr. Porak, of Hôpital St.-Louis, Paris, who believed that by them he had attained the most perfect axis-traction yet devised. The principle

is applied in a very simple manner to any long forceps. Each of the four blades of the spoons is perforated with a small oval hole, as near the centre of the oval of the spoon as possible. Two long tapes are taken, and one passed through the holes of one side; the four free ends are brought down under the forceps, and, after their application, hang out at the vulva. These ends are brought through a hole at the extremity of a traction-rod curved as ordinary traction-rods, with the usual transverse handle at the outer extremity; this is then drawn up to the head, and the ends of the tapes fastened on the rod at the apex of the angle where the vaginal turns down into the perineal curve. The advantages of this forceps are many. 1st. The application is extremely simple. 2d. It can be applied to any forceps. The Tarnier cannot be, as it is only suitable to narrow-heeled instruments. 3d. The child's head is grasped by the centre of its figure, owing to the position of the attachment of the tapes. 4th. This same factor renders unnecessary the screws which are so dangerous in Tarnier's forceps, as the traction does not tend to force the blades apart, but approximates them. 5th. The perfectly movable connection between forceps and rod—i.e., the tapes—allows the head to flex and follow the curve of the pelvic canal.

He had used Tarnier rods and the Poulet forceps on the same patient several times, and his experience accords with that of Dr. Porak: where the Tarnier rods fail and the forceps slip, the Poulet forceps hold and work easily.

Dr. Kelly said, "An interesting incident of a short time since shows the comparative value of axis-traction. I had described my Poulet forceps to a friend who has a large obstetric practice. He sent me a note, asking me to bring my French forceps. I found the head well engaged, but wedged tight. He had made many well-directed vigorous efforts with his own forceps, and finally gave up in despair, producing no effect. I applied the Poulet forceps, and, with a moderate traction on the rod, the head moved gently and steadily until it came directly to the outlet without apparent effort. We were both enthusiastic. No ordinary forceps in the world could have accomplished that." Mr. Gemrig, of this city, keeps the rods on hand: they are the only essential part of the instrument.

Dr. CLEEMANN: There is one feature of Tarnier's forceps which appears to be barbarous and unscientific, and I see this feature is retained in the instrument shown. I allude to the device of the screw, which is intended, by clamping the blades against the child's head, to prevent the slipping of the instrument. Slipping should be prevented by the proper adjustment of the blades to the child's head and the moderate pressure induced through traction. To accomplish such ad-

justment in extreme cases, a pelvic curve should be given to the shank of the instrument. Such adjustment cannot with safety be replaced by the mechanical pressure induced by the screw. (*Amer. Jour. Obstet.*, April, 1878, p. 341, *et seq.*)

Dr. LONGAKER had not had time to read Dr. Winten's article in the original, *Zeitschrift für Geb.*, but gained his information from an editorial in the *Medical News*, which stated that an expectant plan of treatment and forceps are advised for primiparous, and early version for multiparous.

He still thinks the occipito-frontal application of the blades does not appreciably increase the biparietal and bitemporal diameters of the foetal head. It may increase the vertical diameters, as the cervico-bregmatic and sub-occipito-bregmatic. A simple experiment on the manikin of Budin demonstrated the truth of this proposition. A full-term foetus, stillborn, was placed in position at the brim, the sacrum being thrown forward so as to make the conjugate measure three inches. With the axis-traction forceps, the relative disproportion between the head and the pelvis, which was considerable, was easily overcome. With blades having a sufficiently marked cephalic curve the compression need be but slight.

There seems to be some misconception as to what is meant by the head being at the brim of the pelvis. The head is at the brim until the greatest transverse diameter, the biparietal, has passed the plane of the superior strait. With a head entirely above the superior strait, the use of any forceps would hardly be appropriate. If fixation of the head could not be secured, version would be the best measure.

He did not see how traction exerted by means of tapes could be more efficient than with stiff rods.

The fixation-screw is a necessity, there being no free hand to make the necessary compression by the handles. Moreover, it is not objectionable. Continuous pressure is avoided by relaxing the pressure in the intervals. This was one of the chief objections urged by the late Albert H. Smith.

A little reflection and application of well-recognized principles would dictate the proper method of applying traction. Simple axis-traction forceps have been devised by Breus and by Braun.

As version is in almost universal favor in Germany and Vienna, these instruments have little chance; they are scarcely used there.

Dr. BARTON C. HIRST read a paper on

THE DEATH-RATE OF LYING-IN HOSPITALS IN THE UNITED STATES.

Of nineteen thousand nine hundred and two women, delivered in thirty-four hospitals during the years 1880 to 1885, distributed among nineteen large cities of this country,

2.59 per cent. died after childbirth. This death-rate compares very unfavorably with the statistics of hospitals in England, Germany, Vienna, and Paris, and is also more than twice as great as the death-rate of general practice in the cities of this country, which is about one per cent. One and a half per cent. of the women confined should be the maximum death-rate in lying-in hospitals, and, to secure this result, those institutions should be subjected to State or municipal supervision.

Dr. BALDY thought that, in comparing American lying-in hospital reports with those of foreign countries, especially those of Germany, we would not find the former to hold an inferior position. According to Dr. Dohné's statistics, the average mortality in Germany before antiseptics were introduced was 3.4 per cent. Comparing this with the 2.5 per cent. mortality as given by Dr. Hirst for American hospitals, we stand about even,—our apparent advantage being due to the fact that their 3.4 per cent. were without any antiseptic, our 2.5 per cent. included a few years of antiseptis. Comparing the years of complete antiseptis in both countries, we still hold our own, Dr. Dohné giving the German an average mortality of 1.37 per cent., Dr. Hirst giving us a mortality of 1.31 per cent. for the Boston Lying-in Charity, and 1.52 per cent. for Blockley Almshouse, Philadelphia, with a mortality of less than one per cent. for the past year in the last-named institution. The mortality of private practice and hospitals scarcely admits of comparison.

Dr. Baldy considers modern midwifery too meddlesome. The practice of introducing the examining finger and manipulating the patient every fifteen or twenty minutes is a great source of danger. This is evident on reference to Dr. Dohné's statistics. In hospitals, even under antiseptis, where students of medicine are taught, the percentage of mortality is given as 1.90; where midwives are trained, 1.13 per cent.; where there is no teaching whatever, 0.56 per cent.

Two great sources of puerperal fever, so called, are lacerations of the soft parts and diseased appendages. If the laceration were always dealt with primarily, and the appendages examined and dealt with as required, our mortality would drop to almost nothing. While he was an interne at Blockley Almshouse, the vast majority of women delivered suffered from perineal tears, and in every one of these cases there was a rise of temperature that was called puerperal fever. There were no attempts at closure and no antiseptic precautions. A patient is now under his care who was delivered a month ago of a stillborn child. On the third day she experienced a rise in temperature, with all the signs of a puerperal fever. An examination disclosed a pyosalpinx, which will have to be removed to save her life.

Dr. HIRST admitted that before the introduction of antiseptics the statistics of German hospitals were worse than those of our hospitals at the present time.

PERINEORRAPHY AS PERFORMED BY DR. W. GILL WYLIE.

Dr. HOWARD H. PARDEE: The interest shown in the paper describing Dr. Emmet's operation for the restoration of the perineum, read at the February meeting, led me to think that a brief description of the operation devised by Dr. Wylie might also be acceptable to the Society.

According to a paper by Dr. Wylie, contributed to the *New York Medical Record*, March, 1885, he had devised this operation about five years previously. It was first performed before a class, so far as I know, in a ward in Bellevue Hospital, New York, in the winter of 1882-83. It is the operation as I then became acquainted with it that I shall describe, for it is the one I have since used and am most familiar with. A letter received from Dr. Wylie a few days ago tells me that he still uses the same operation, with little if any modification. It is performed as follows.

The usual preparation by laxatives, hot douches, and glycerin tampons having been carried out, the bowels are cleaned by an enema an hour or two before the time for operation. Just before the patient is etherized, a hot vaginal douche of corrosive sublimate, one to five thousand, or carbolic acid, one to forty, is given. The patient is placed on her back, the buttocks as near the edge of the table as possible, with the thighs strongly flexed and the knees held apart by an assistant on either side. The labiæ are drawn apart as fully as possible without straining, and are held by the assistants. The caruncles marking the posterior border of the vaginal orifice are found, and mark the limit of the denudation upward or towards the pubes. A tenaculum is hooked into the crest of the rectocele, which is drawn down, and an examination is made with the finger to find at what point the tissues on either side of it are put on the stretch by the traction. This point, or one a very little above it, is made the limit of a denudation backward into the vagina. It is well to mark it by snipping off a particle of the mucous membrane on either side. For the denudation, a pair of moderately sharp-pointed scissors curved on the flat is the most convenient instrument. Following Dr. Wylie's example, I have always used a pair of good dissecting-forceps to catch the tissues, instead of the tenaculum. Commencing from below, a strip of mucous membrane as wide as can be conveniently cut is snipped off, following the line of junction of the skin and mucous membrane from the level of the inferior caruncle on one side to the same level on the other. We then denude all the

posterior surface of the vagina up to this level till we reach the beginning of the sulci running on either side of the rectocele. The part of the operation requiring the greatest judgment has now come. Our object is to unite the vaginal wall above the sulcus on one side with the corresponding portion of the vaginal wall on the other side, so obliterating the sulci and forcing back the rectocele. If we carry our denudation too high, we shall find it difficult to bring the two sides together without undue tension. If we are too timid, our support will be insufficient and our operation will be but a partial success.

The proper level having been determined, we continue the denudation upwards till we reach the points in the vagina which we marked out as the limit of tension from the apex of the rectocele. This will usually be about one and a half or two inches from the orifice. In denuding this portion of the vagina, we still work from side to side, carrying the strip of mucous membrane down into the sulcus, up over the rectocele, down into the other sulcus, and up to the level we have marked on the other side. In doing this we should not cut very deeply, and preserve as much as possible of the muscular substance of the wall of the vagina over the rectocele; but afterwards we should go over our work in the sulci, removing all tissue, till we come to the firm fibrous external sheath of the vagina. In this way we hope to preserve a firm muscular coat over the rectocele. When we are through, the denuded surface will be nearly square, or, if the rectocele be very large, a parallelogram, the greatest length being transverse to the axis of the vagina. All bleeding should be controlled preferably by pressure and torsion, but, if necessary, catgut ligatures may be used, and the parts washed thoroughly with some efficient antiseptic.

The sutures should now be introduced. The first three or four are placed as in the old "butterfly" operation, entering about a quarter of an inch outside the line of junction of the skin and mucous membrane, passing backward and downward, and then upward and forward, emerging on the other side at a point corresponding to the point at which they entered. The last one of these external sutures should be entered a little above the level of the caruncle which marked the limit of denudation upward. The remaining sutures, four or five in number, are usually entered in the mucous membrane a little above the line of denudation, passed down below the angle formed by the sulcus, and up to the crest of the rectocele. It is best to bring the needle through at this point and re-introduce it at the same point; it then goes down the other side of the rectocele, round the angle of the sulcus, and up the opposite vaginal wall till it emerges above the line of denudation, opposite the point where it entered on the other side. This may seem to be a difficult

stitch; but, with a straight needle, a good needle-holder, and the index finger of the left hand in the rectum, while the thumb is in the vagina, it is made without much trouble. The greatest care should be taken that the needle is buried when it passes under the angle of the sulcus. When the sutures are placed, and before they are tightened, the sphincter ani should be thoroughly stretched. This to a certain extent relieves the tension on the sutures, and at least adds largely to the comfort of the patient by preventing straining at stool. Another thorough cleansing of the parts should now be done, and the sutures should be tightened from below upward. The urine is not drawn unless the patient is unable to pass it; the parts are washed after urination.

Dr. PARISH had for years performed a similar operation, but carried his denudation farther up the vagina, and thus avoids the formation of a pocket-like place in which discharges accumulate. He has found it in some cases a cure for constipation.

Dr. BALDY did not think Dr. Pardee understood Emmet's operation.

Dr. PRICE prefers Emmet's operation.

Dr. H. A. KELLY thought this an unsatisfactory modification.

Dr. PARDEE was well acquainted with Emmet's operation as performed two and a half years ago. The obliteration of the rectocele in that operation was by drawing down a stretched wall, leaving it thin over the rectocele. In his experience, opium had not been needed after the operation to control pain. The external stitches are needed to secure a neat external healing.

Dr. JOSEPH PRICE exhibited a specimen of

DOUBLE PYOSALPINX WITH COEXISTING OVARIAN CYSTOMA ON BOTH SIDES.

Mrs. H., æt. 30 years, two children, labors normal, complains of irregular and profuse bleeding, constant pelvic pain, greatest on left side. General health poor. Examination revealed a small fibroid on posterior wall of the uterus, a cyst on the right side extending high up, and inflammatory masses laterally.

Operation.—On section, the appendages on both sides were found distended by pus and generally adherent; left ovary cystic and suppurating, and matted to the pavilion of the tube and the sigmoid flexure. The right ovary was cystic and adherent to the vermiform appendix. The pelvis was filled with an irregular conglomeration of cysts and pustules, intimately adherent to pelvic organs, and overlying all this were the bladder and omentum, also firmly adherent. The omentum was perforated at two points, and the mass was removed by careful dissection. A glass drainage-tube was used; recovery was rapid and perfect; no opium, no catheter; tube out on fourth day; stitches out on seventh day.

Dr. W. H. PARISH reported a

FORRO-MÜLLER OPERATION,

performed by Drs. O. H. Allis and W. H. Parish because of an impacted shoulder-presentation. Mrs. L., æt. 26 years, of small stature but good general health. When about six months pregnant she had been hooked by a cow and narrowly escaped a miscarriage. She reached full term, and had been in labor seven days when Dr. Allis was telegraphed for by Dr. Groom, of Bristol, Pa., in whose care the patient had been. The membranes had ruptured four hours after the pains began. On the sixth day the pains became more severe and the cord prolapsed. About the same time a hand protruded from the vagina. The child died also about this time. Version had been tried by Dr. Groom and others without and with anæsthesia, but could not be effected. The child was evidently of large size. The patient was restless, exhausted, and with a pulse of 120 per minute. The pains were constant, and the uterus was firmly contracted about the child. The patient's surroundings were unfavorable: the ignorance and poverty of the family rendered proper nursing impracticable. An offensive sanious fluid was escaping from the uterus; the cervix was rigid and but slightly dilated. It seemed impossible to deliver the patient by either cephalic or podalic version, and the conclusion was made that evisceration was not advisable because there was every reason to believe that the uterus had done itself irreparable harm by reason of its prolonged retraction against the eminences of the child. The contusion incident to the retraction and the admission of atmospheric air over a period of seven days, with the character of the discharge, rendered it certain that gangrenous changes had been going on in the endometrium and placenta, and that septic inflammatory action of the uterine lymphatics had already begun. The patient was in a condition of exhaustion. Evisceration alone would not have sufficed to secure delivery: it would have been necessary to bisect the child in the lumbar region and to remove separately the lower and upper sections. The condition of the uterus and the small size of the pelvis would have rendered this procedure a lengthy and an exceedingly difficult one, and would have involved additional serious injury to the uterine tissues. The removal of the child would have left a putrefying endometrium and septic lymphatics. It was thought that the patient would certainly die if thus delivered. All present thought Cæsarean section warranted.

The operation was performed by Dr. Allis. The uterus was elevated from the abdomen, and a rubber tubing was placed about the cervix, securely controlling the hemorrhage. Escape of fluids from the uterus was guarded against by means of warm antiseptic pads

adjusted about and over the abdominal incision. A vertical incision was now made, and the child extracted without difficulty; the placenta was not in the line of incision, and there was no hemorrhage. Two transverse pins were carried through the cervix, and a constricting wire was substituted for the rubber tubing about the junction of the cervix with the body of the uterus. With the uterine body were removed also both broad ligaments and their contents. The uterine stump was secured externally by means of the transfixion-pins, and wounds closed by carbolized-silk sutures. Antiseptic measures were taken throughout the operation, but the spray was not used. Immediately after the operation the pulse was 130 per minute. The patient died in forty-eight hours, apparently from heart-failure.

A full account of this case will be found in the *American Journal of Obstetrics*.

Dr. R. P. HARRIS remarked that the Cæsarean operation had been performed in the United States in cases of impaction of the fœtus in a transverse position twelve times. In eleven cases the fœtus was dead. In the twelfth it was saved; but the operation was believed to have been uncalled for by a physician who performed laparotomy with success after the woman had ruptured her uterus in her next labor. The pelvis had been computed to have a conjugate and a transverse diameter of three inches. In one other of the twelve cases the pelvis was deformed and the woman saved. The arm was protruding in seven cases, five of which recovered. In two the shoulder presented,—one saved; and in three the presenting part is not named. Of the twelve cases, nine, or seventy-five per cent., recovered. Of the three cases lost, one was ninety-six hours in labor, three days in charge of a midwife; another was twenty-six hours under a midwife who had given ergot and ruptured the membranes; and the third had been long in labor, but time not stated. Her death was caused by fright and exhaustion. She rose from her bed to defend her mother against her husband, who had come home drunk on the third day. He knew of but one case of impaction in Europe in which the Porro operation was performed; but in this the pelvis was deformed. The operation was by Fehling, of Stuttgart, and the woman was saved. Putridity of the fœtus may require the removal of the uterus in a case of impaction. One woman was saved without its removal, in the United States, after seven, and another after ten, days of labor, by uterine suturing to prevent escape of fluid; but it is safer to remove the organ when there is danger of poisoning, and particularly where the patient appears to be already threatened with it. In the Porro case of Candido Ramello, of Turin, the woman had been six days in labor, the fœtus was putrid, and the mother in great danger of septicæmia. The

removal of her uterus with its contents was followed by improvement of her symptoms, and she recovered.

W. H. H. GITHENS,
Secretary.

PHILADELPHIA ACADEMY OF SURGERY.

At the stated meeting of the Philadelphia Academy of Surgery held March 7, 1887, the President, Dr. D. Hayes Agnew, in the chair, Dr. J. Ewing Mears read a paper entitled "The Progress and Limitations of Operations upon the Abdominal Cavity."

Dr. John H. Packard reported

A CASE OF GUNSHOT-WOUND OF THE ABDOMEN,

in which nine wounds of the intestines and one of the iliac vein were produced. Laparotomy was performed, and resection of a portion of the intestine was made, with closure of the other wounds by suture. The patient died in a few hours following the operation. At the autopsy the hydrostatic test showed that the closure of the wounds by the sutures was complete, and that all the wounds had been found and secured.

DISCUSSION.

Dr. J. Ewing Mears: Dr. Packard has alluded to the sutures to be employed in closing wounds of the intestine. Operators on the abdominal cavity have insisted upon the importance of using such a suture as will bring the serous surfaces fully together, and as much of the surface as is consistent with the preservation of the calibre of the intestine. Mr. Wells says that this is the great fact which has been learned from operations on the abdominal cavity in cases of ovarian disease. An important point with reference to the suture to be employed in closing wounds of the intestine is that one should be employed which will not permit separation under the influence of the peristaltic action of the bowel. The Lembert suture seems to me to accomplish that better than any of the other sutures which have been proposed.

In cases in which there is a wound of the liver, Dr. Senn has recommended that the wound be plugged with iodoform tampons, the tampon to be allowed to remain. If the wound is in an aseptic condition, the aseptic foreign material will, in course of time, become encysted. Suturing wounds in parenchymatous tissues, such as that of the liver, is a very unsuccessful operation. The needle employed in these operations should be round, and smaller than the catgut suture which it carries.

Dr. Charles B. Nancrede: Having been the first to perform laparotomy for gunshot-wound of the intestines in this city, although I was not then acquainted with Dr. Bull's and others' methods of operating, I recognized the objec-

tions to the triangular needle, and employed a cambric needle with very fine silk. I do not see that catgut has any advantage over fine silk. I was able in this way accurately to coapt the wounds,—so accurately that, although the stomach (which had in its walls two large wounds) was forced out of the abdominal wound in the efforts at vomiting, and I had considerable difficulty in replacing it, nothing escaped. I used the Lembert suture, and it was perfectly air- and water-tight. My colleague, Dr. Forbes, in a case in which he resected about six inches of the bowel, used a combination of the Czerny and Lembert sutures which answered admirably. I do not think that the Gély suture would save any more tissue than the Lembert in ragged wounds of the intestine. When this subject was recently discussed at the meeting of the New York State Medical Association, I think most of the speakers recommended the use of the ordinary sewing-needle.

Dr. J. H. Packard: I used the triangular needle because it happened to be the best at hand; but it several times cut vessels in the mesentery or mesenteric border of the intestine of sufficient size to require tying, thus causing delay. I have since procured from Mr. Gemrig some needles made from ordinary sewing-needles of large size by cutting them off and re-sharpening them. The eyes are quite large enough to carry the fine gut which I used, and there is no lateral edge to endanger the vessels. The fine chromicized gut was used because it was in readiness, and I think it answered as well as silk.

The Lembert sutures were placed about one-eighth of an inch apart. For some reasons, Gély's suture seems to me preferable; but I should not make it continuous, as proposed by him. Instead of crossing the ends and re-inserting them in the intestinal wall, I would simply tie them, and start afresh. When used continuously, I should think it might produce an undesirable longitudinal puckering of the bowel. The advantages of it seem to me to be that it involves the turning in of less of the edges; that the longitudinal portion of it serves as a sort of splint for the tissues; and that some time is saved, as in each application progress is made along the wound as well as across it. I know of no recorded observations as to the comparative security afforded by these methods respectively.

The President, Dr. D. Hayes Agnew, presented a gallstone removed by cholecystotomy, and also a renal calculus removed by nephro-lithotomy.

DR. WILLIAM GOODELL having resigned from the Preston Retreat, Dr. Joseph Price has been unanimously elected to succeed him, as Physician in Charge, by the Board of Managers.

PHILADELPHIA CLINICAL SOCIETY.

STATED MEETING, FEBRUARY 25, 1887.

The President, Dr. JAMES B. WALKER, in the chair.

THE PRESIDENT introduced the subject of

ARTIFICIAL FEEDING OF INFANTS.

The importance of the subject all will admit, and depends upon (1) the inability of the mother to afford nourishment; (2) the demands of the child for the materials for growth, repair, and heat-production; and for *protection* from indigestion and the numerous disorders of malnutrition. The prominent indications of the non-agreement of any food are excessive colic, vomiting, diarrhœa. The results are seen in losses of flesh, strength, vivacity, and color, non-development of general body or of parts, as of teeth, retardation of infantile accomplishments, psychical or physical, or even loss of those which have existed. One or many of these conditions may exist and call for attention on the part of the physician to the imperative needs of the little patient.

In choosing a diet there is no established *law* save that the food shall be easily digested, non-irritating, and suitable for nourishment and heat-production. If the infant have been nursing its mother, the *quantity* may be alone at fault. In all such cases artificial food should be made to *supplement* and *not* to *substitute* the natural supply. The amount of artificial food must vary with each case from every alternate feeding to two or three feedings daily. Should the *quality* of the mother's milk be at fault, or should she be unable to nurse her child from other causes, a complete *substitute* must be furnished.

Here, unquestionably, the best, because furnishing the most rational substitute, is the wet-nurse. But, rational though it be, it has objections which sometimes are insurmountable. Among these are the expense incurred, the difficulty of getting one whose milk is altogether satisfactory, or, this agreeing, the unsatisfactoriness of the individual herself, who, reins in hand, may, if inclined, drive the family to distraction. Apart from this, many mothers object to having their little ones nurse at other breasts than their own, even when the substitute is cleanly in person, character, and habits, and much more so if doubt exist, as it often must, upon these scores. While not decrying wet-nurses,—indeed, while claiming that for some infants they are our only means of salvation,—the lecturer claimed that in most instances they are not indispensable.

In choosing a substitute for human milk for healthy children, the lecturer does not approve of the so-called infant-foods manufactured on large scale and kept on the drug-

gist's shelves. These substances, many of which have much virtue, find a sphere in the management of the sick, but as a rule may be eschewed in arranging a food for the well.

For most babies condensed milk answers best for the first three to six months of life. Here again a choice may be made. There are several varieties of this food, most of which are supplied in quantities to grocers and druggists, and lie an indefinite time on the shelf or counter, during which time they are liable to deterioration. This is not a matter of theory, but has been proved in more than one instance by an attack of severe indigestion and diarrhœa on opening a new can. The brand most satisfactory in the lecturer's experience is Canfield's, which is manufactured in Philadelphia, and is for sale only at the manufacturer's office, where its freshness and purity are guaranteed. Or, if the sweetness of the condensed milk be an objection in an individual case, the "Evaporated Cream," a partially condensed milk prepared by the same firm, may be used, having it served fresh every day or every alternate day. Unquestionably, condensed milk is preferable for the young infant to the fresh (?) milk furnished by the middleman in our large cities.

If a child taking condensed milk is constipated, a small quantity of Mellin's, Horlick's, or Nestlé's food may be used in each bottle, and will usually be all-sufficient.

At least until a food has proved satisfactory, the infant should be weighed at the end of each week, and should gain from three or four ounces to a pound weekly. If severe colic, vomiting, or diarrhœa occur without cause, such as teething, exposure, etc., some change is indicated. This will usually be the case, where condensed milk is the diet, somewhere from the third to the eighth month. The addition of oatmeal to the food may be all that is needed. It should be thoroughly cooked for three hours, then strained through a cloth, producing a white, semi-translucent substance about the consistency of starch as used by the laundress. Of this from one to three tablespoonfuls may be added to each bottle, according to the age of the child and its powers of digestion. Lime-water is an important addition to the artificial food, and should be used continuously for the first ten or twelve months.

In most instances fresh cow's milk will have to be substituted for the condensed milk when the latter disagrees, or this, if obtainable pure, may be used from the first. This should be diluted to suit the age, and have added sugar, lime-water, and from a teaspoonful to two tablespoonfuls of cream to each bottle, varying the amount to suit the condition of the bowels. After the third month, or even before, some of the oatmeal-gruel, prepared as already directed, may be added. In cities, all the water used in preparing the food should have been previously

boiled. Sometimes an irritable state of the bowels, induced by one of many causes, may be benefited by the substitution for a few hours of barley-water, arrowroot-water, or gum-arabic water, and on resuming the milk-food one of the above waters may be used as the diluent, instead of plain boiled water. Sometimes the use of peptonized milk diluted with barley-water, or the addition to the milk-food of the "Peptogenic Milk-Powder" of Fairchilds, Brother & Foster, may be required for a shorter or longer period.

In the artificial feeding of infants the plain nursing-bottle with pure rubber nipple is better than spoon-feeding, giving exercise to the masticatory apparatus and stimulating to more rapid functional development the salivary function.

The subject was discussed by the different members, and the experience of each one proved that cow's milk in some form was the best food for a child who must be artificially fed.

Dr. ANNA McALLISTER spoke of some interesting experiments which had been tried at the New York Infant Asylum, under the supervision of Dr. J. Lewis Smith: where, in several autopsies on artificially-fed infants, it was found that in those fed on *starchy* food the pancreas was very small, seemingly arrested in its development, while in those fed upon *condensed milk* the organ was normal in size.

Dr. EDWARD R. STONE gave a verbal report of a case of uræmic convulsions in nephritis following scarlet fever in a child 6 years of age, in which a hypodermic injection of one-twelfth grain of muriate of pilocarpine gave most satisfactory results. The child had been in convulsions all day, but they were speedily checked after the administration of the remedy, salivation and diaphoresis setting in almost immediately. "Basham's Mixture" was used afterwards, and the child made an uninterrupted recovery.

MARY WILLITS, M.D.,
Reporting Secretary.

1527 GREEN STREET.

NEW YORK ACADEMY OF MEDICINE.

A STATED meeting of the Academy was held March 3, 1887, the Vice-President, CHARLES C. LEE, M.D., in the chair.

THE PATHOLOGY AND TREATMENT OF EPILEPSY, BASED UPON NOTES OF SIXTY CONSECUTIVE CASES IN PRIVATE PRACTICE.

Dr. WILLIAM H. THOMSON read the paper. He observed that the most striking features of a disease were often the least important: this he considered to be true regarding the motor or convulsive phenomena in epilepsy, which are only accessory. He did not look upon epilepsy as necessarily a convulsive disorder

at all. It had been said that its primary and essential element consists in an explosive or active discharge of nerve-cells. For this definition he would substitute the following: epilepsy is a disease characterized by sudden but temporary loss of function on the part of one or more cerebral centres, the attacks being introduced probably in every case by an afferent impression.

To illustrate his meaning he cited the case of a man who, although he had the convulsive phenomena of epilepsy, had at other times only sudden and temporary aphasia, not being unconscious; at other times there was a loss of consciousness and a convulsion; there was also the initial aura. He asked what these different attacks were, if they were not true epilepsy? and, if so, how could the motor or convulsive phenomena be absent and yet be an essential element of the disease? He therefore claimed that the essential and invariable element in epilepsy is suddenness of onset, and that this is the only truly sudden disease. Other diseases in which suddenness seems to figure are only apparently so. Among these are laryngismus stridulus, spasmodic asthma, hemiplegia, etc. As distinguished from epilepsy, hysterical attacks are preceded by emotional excitement. Neuralgia, chorea, mental disturbance, are affections more or less progressive. They may be rapid in their onset, but never sudden in the sense that epilepsy is. A sudden mental derangement is always epilepsy, and therefore all recurring symptoms, whether sensory or motor, when characterized by suddenness are ominous, because suggestive of epilepsy. The more marked motor phenomena are not necessary in epilepsy in order that the more grave mental phenomena of that disease may occur. Mental degeneration and homicidal mania follow equally upon the seemingly insignificant symptoms of *petit mal* as upon the seemingly grave symptoms of *grand mal*. So far as the results go, nothing could be more complete than the minor disease.

Dr. Thomson then considered the theory, generally believed in, that epilepsy is attended by a cell-discharge or explosion. He thought that this is only apparent, and not founded on fact. For instance, a man walking rapidly, if he should have the ligamentum patellæ cut suddenly, would not only fall, but would experience a shock more serious than the cutting of the ligament, because of the sudden interruption of the organized and harmonious action of the motor-nerve centres. It could be said that whereas convulsive movements could be initiated by direct irritation of the motor ganglions either in the spine or the cortical gray matter of the brain, yet the movements in an immensely preponderating number of cases are not thus initiated, but are the consequence of sensory influences, either excitant or the reverse. Any sudden sensory impression occur-

ring during motor action might in an instant turn the previously regulated motion into a virtually powerful unregulated convulsion.

Ever since he had become satisfied that the primary lesion of epilepsy was to be found in the sensory and not in the motor department of the nervous system, and that it was one characterized by lack of nutrition and not a surplus of energy, he had studied the application of this principle to treatment. While he often used to feel discouraged with the therapeutics of epilepsy, he was now growing less so, as by perseverance in spite of the recurrence of convulsions many obstinate cases finally yielded. The first object is to improve nerve-nutrition, and this can be done in many cases by cod-liver oil. This agent also tends to prevent the impoverishment of the blood by the bromides. For this purpose next comes phosphorus. He recommended a diet of milk, eggs, fish, in the place of animal flesh. Too rapid eating should be avoided, and attention should be given to the functions of the alimentary tract. For quieting sensory excitability, he gave bromides. If there were indications of persistent cortical irritation, he employed corrosive sublimate. He used belladonna whenever there were symptoms related to the digestive tract. Chloral hydrate was sometimes useful at night. Digitalis was useful where there was pronounced vascular disturbance or symptoms connected with the genito-urinary tract. One expedient which he often used with striking results was a mustard or red-pepper pack.

Dr. L. PUTZEL thought the prodroma of epilepsy, sometimes lasting two or three days, were against the idea that it was always a sudden disease. He did not think that the paralytic attacks in *petit mal* were frequent, and when they did occur he thought that they were the result of exhaustion from prolonged convulsions. He did not think the convulsions which children had when teething, and which did not continue, were epilepsy; they were only epileptiform.

Remarks were made by Drs. W. H. DRAFER, PUTNAM JACOBI, and E. D. HUDSON.

Dr. A. D. ROCKWELL read a paper on

THE VALUE OF ELECTRICITY IN THE TREATMENT OF EPILEPSY.

If he were asked directly whether electricity was of any value in the treatment of epilepsy, he would unhesitatingly answer in the affirmative. There was a certain proportion of cases which, failing to receive more than temporary benefit from bromides, might recover when that treatment was reinforced by the judicious application of electricity. He cited one case in which there had not been a recurrence of the attacks for four years after the commencement of treatment by electricity combined with the usual therapeutics. The entire number of cases of epilepsy in which he had employed electricity since 1874 was twenty-eight. Ten

had abandoned the treatment too quickly to estimate its value. In three cases in which it was given a fair trial it did not aid the bromides in controlling the disease. In eight other cases which were under observation from six weeks to nine months the good effect of the treatment was manifest in a greater or less degree. Recovery took place in two.

It was not known, nor was it claimed, that electricity used alone would cure epilepsy; but used in connection with bromides its value was unmistakable, and under its use a certain proportion of the cases would recover which otherwise would not. He employed central galvanization and general faradization. Many epileptics were benefited by the influence upon their general neurasthenic state. The systematic use of electricity made the system more tolerant of the bromides. Electricity should be used with care and judgment. Especially should the physician using it avoid interruption of current in central galvanization, which he relied upon chiefly.

Drs. FISHER and THOMSON made some remarks upon the paper.

REVIEWS AND BOOK NOTICES.

A PRACTICAL TREATISE ON THE MEDICAL AND SURGICAL USES OF ELECTRICITY. By GEORGE M. BEARD, A.M., M.D., and A. D. ROCKWELL, A.M., M.D. Fifth Edition. Pp. 30, 758, large 8vo. New York, Wm. Wood & Co., 1886.

From beginning to end this work shows a painstaking desire to set forth the claims of electricity as a therapeutic agent in medicine without exaggeration of its merits. In its pages the latest ideas are recorded, and the chapters on electro-physics, electro-physiology, and electro-diagnosis are noteworthy for their fulness, clearness, and adaptation to the wants of every-day practice. No book on the subject by an American author will rank with this volume in intrinsic value, and it is simply indispensable in the library of the thinking and reading physician. The index and glossary are very comprehensive.

W. R. D. B.

MISCELLANY.

OLEOMARGARINE LEGISLATION.—The war over oleomargarine wages vigorously, and the decision just rendered by the Supreme Court of Pennsylvania will tend to complicate the question. The Court of Appeals of New York a short time since decided that it was not constitutional to prohibit absolutely the manufacture and sale of oleomargarine, this product not being deemed unhealthy when properly manufactured. It was held proper to regulate the

sale and prevent its being offered for genuine butter, but the absolute prohibition of all manufacture and sale was held improper. The Supreme Court of Pennsylvania now takes part in the discussion and decides directly opposite to the New York court. The case involved about the same question, and the court says, "The manufacture, sale, and keeping of an article may alike be prohibited by the Legislature, if in their judgment the protection of the public from injury and fraud requires it. To deny the authority of the Legislature to do so is to attack all that is vital in the police power."

NEW JOURNALS DEVOTED TO THERAPEUTICS.—In Germany, Drs. Liebreich, Langaard, and Rabow are the editors of a new medical monthly devoted to clinical medicine and new remedies. In France, Dr. Henri Huchard will edit a medical weekly entitled the *Revue Générale de Clinique et de Thérapie*, the first issue of which appeared February 17. The material in these journals, consisting of original contributions, clinical lectures, annotations on new remedies, and reports of societies, promises to be of great interest and value to the profession.

NOTES AND QUERIES.

A REMARKABLE CASE OF INJURY TO THE PERINEUM.

MR. EDITOR,—On the 27th of December, 1886, I was called to see a son of Mr. J. B. H., of West Wateree. Mr. H., who came for me, told me that his son was running along after a wagon, sliding a shovel in front of him, holding the handle with his hands in front of him, when the shovel struck against a stump, and the handle was forced through "his son's gus." He found his son in a faint, and had to employ considerable force to extract the shovel-handle. He further stated that the handle punched a round hole through the penis, shirt, and drawers of his son.

I found that the handle belonged to an ordinary road-scoop-shovel, and measured one and one-half inches in diameter, and was rounded on the end. When I reached the patient, who is about 21 years old, he was lying before a fire in apparently no pain. On inspection, I found a round hole punched, though it looked as if it had been cut, through the pants, shirt, and drawers, a little tear on the right side of the penis, an inch from the end, and a semilunar cut or tear on the anterior surface of the scrotum, being nearly on the median line, but a little to the right. On digital exploration, I found an opening clear through the scrotum, entirely as above stated, and tearing its way out under and through the perineal skin and superficial fasciæ, barely missing the external sphincter ani muscle. The hole was so large that I could easily put my thumb through it. I could detect no injury to the right testis.

I stuffed the wound with iodoform, after washing with carbolyzed water, and left a drainage-tube running clear through the scrotum, which was also partly filled with iodoform. The penis being also dressed with iodoform, I padded the injured parts with absorbent cotton, fixed a bandage to support the genitals, and had the patient put to bed, ordering quin. sulph., gr. xx, as a safeguard against traumatic fever.

The patient's residence being in the country, he was not seen until on the 30th inst., when, being sick, I got Dr. B. to see him for me. He found no fever, very little pus, scarcely any inflammation, and only a little soreness in the parts, the small wound on the penis giving more pain than the larger wound in the scrotum. The iodoform-treatment was continued, being injected through and around the drainage-tube while suspended in glycerin and water.

I saw him again on January 6, 1887, and found everything looking healthy, scarcely any pus or pain, and no fever. I took out the tube and ordered the iodoform-treatment to be continued, and to be injected as before carefully as long as

there was any opening in the scrotum. In a few days over a month from the time he was hurt, the young man was at work.

What I consider so remarkable in this case is that, notwithstanding the wound made by the one-and-one-half-inch shovel-handle through the scrotum and perineum to the anterior edge of the external sphincter ani, there was no fever, suppuration, nor pain worth noting. I am inclined to think that the kindly healing of the wound without any trouble was due to the iodoform. I always use iodoform very freely, and have never seen any harm from it, except, when using it in a case of ulcer and fissure of the anus, I noticed, after a free use of it, there was brought on a pruritus; and I noticed this only once.

Is there on record a case like this in any respect? If there is, I would like to hear of it. I have never heard or read of any wound similar to this in its nature, cause, or way of healing.

JOHN W. CORBETT, M.D.
CAMDEN, SOUTH CAROLINA.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT U.S. ARMY FROM MARCH 13, 1887, TO MARCH 26, 1887.

CAPTAIN WILLIAM W. GRAY, ASSISTANT-SURGEON.—Leave of absence further extended two months. S. O. 62, A. G. O., March 17, 1887.

CAPTAIN WILLIAM F. CARTER, ASSISTANT-SURGEON.—Leave of absence extended four months, on surgeon's certificate of disability. S. O. 57, A. G. O., March 11, 1887.

FIRST-LIEUTENANT GUY L. EDIE, ASSISTANT-SURGEON.—Leave of absence extended three months. S. O. 67, A. G. O., March 23, 1887.

FIRST-LIEUTENANT JEFFERSON W. POINDEXTER, ASSISTANT-SURGEON (recently appointed).—Ordered for temporary duty at U. S. Military Academy, West Point, New York, relieving Captain Richard W. Johnson, Assistant-Surgeon, who will return to his proper station (Fort Adams, Rhode Island). S. O. 62, A. G. O., March 17, 1887.

CAPTAIN FRANK REYNOLDS, ASSISTANT-SURGEON (retired). Died March 4, 1887, at Oakland, California.

OFFICIAL LIST OF CHANGES IN THE MEDICAL CORPS OF THE U.S. NAVY FOR THE TWO WEEKS ENDING MARCH 26, 1887.

SURGEON J. B. PARKER.—Ordered to the U.S.S. "Osage."

SURGEON C. A. SIEGFRIED.—Ordered to Baltimore, Maryland, on special duty.

SURGEON JOSEPH HUGG.—Placed on Retired List, March 17, 1887.

ASSISTANT-SURGEON F. J. B. CORDEIRO.—Detached from Navy-Yard, Boston, and placed on waiting orders.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U.S. MARINE HOSPITAL SERVICE FOR THE TWO WEEKS ENDING MARCH 26, 1887.

BAILHACHE, P. H., SURGEON.—To proceed to Mobile, Alabama, Pensacola, Florida, Ship Island, Mississippi, and New Orleans, Louisiana, as inspector, March 14, 1887.

LONG, W. H., SURGEON.—Granted leave of absence for seven days, March 16, 1887.

GOLDSBOROUGH, C. B., SURGEON.—Granted leave of absence for thirty days, March 14, 1887.

DEVAN, S. C., PASSED ASSISTANT-SURGEON.—To proceed to Tacoma, Washington Territory, as inspector, March 19, 1887.

LONG, W. H., SURGEON.—Leave of absence extended five days, March 23, 1887.

URQUHART, F. M., PASSED ASSISTANT-SURGEON.—Relieved from duty at Norfolk, Virginia; ordered to Washington, D.C., special duty, March 22, 1887.

PETTUS, W. J., ASSISTANT-SURGEON.—When relieved by Assistant-Surgeon Guiteras, to remain at Charleston, South Carolina, "waiting orders," March 24, 1887.